



**Request for Prior Authorization**

**MULTIPLE SCLEROSIS AGENTS-ORAL**  
(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Requests for non-preferred oral multiple sclerosis agents:**

Document trial of preferred oral multiple sclerosis agent:

Drug Name & Dose \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure Reason \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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***IMPORTANT NOTE:*** *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*