



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Novatrone

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

- Which drug is being prescribed?
 Novatrone, Dose: _____ Frequency: _____ Other _____
- What is the diagnosis? Multiple Sclerosis (MS) Other _____
- Which form of MS does the patient have?
 Primary progressive MS
 Progressive relapsing MS
 Relapsing - remitting MS
 Secondary progressive MS (with or without relapses)
- Attach documentation of the following:** Document Attached
 - Baseline or Current left ventricular ejection fraction (LVEF)
 - Complete blood count (CBC) with differential, and
 - Lifetime Novantrone dose
- What is the patient's baseline OR current left ventricular ejection fraction (LVEF)?
Baseline (LVEF) _____ % **Current (LVEF)** _____ %
- What is the patient's absolute neutrophil count (ANC): _____ cell/mm³
- What is the patient's lifetime dose of Novantrone: _____ mg/m²
- In light of the boxed warning, has the patient been advised of the risk of secondary acute myeloid leukemia occurring in patients treated with Novantrone? Yes No
- Will Novantrone be used as monotherapy? Yes No
- Is the patient currently on Novantrone therapy? *If Yes, continue to # 11* Yes No

Only answer below questions if patient is currently on therapy.

- Has Novantrone been effective? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

12. If No, is there a clinical reason for lack of efficacy? Yes No

13. If Yes, Document clinical reason for lack of efficacy: _____ (**FAX Clinical**)

****NOTE: We can NOT make a decision without a copy of the results - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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