



**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Gilenya® (fingolimod)**

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of **Gilenya® (fingolimod)**. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required) _____	Member ID Number: (required) _____
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)
Prescriber Name: (required) _____	Contact Person at Office: _____
Office Phone number: (required) () -	Office Fax Number: (required) () -

Directions of use: _____ Quantity _____ Duration of Treatment _____
Neighborhood’s criteria for approval of Gilenya® requires that the patient has failed an appropriately dosed recent trial with at least 1 form of interferon and Copaxone® due to inadequate response and/or intolerance

Please Check all that apply:

<input type="checkbox"/> Patient has failed appropriately dosed recent trial with at least 1 form of interferon. Drug _____ Date _____ <input type="checkbox"/> Inadequate response(describe) _____ <input type="checkbox"/> Side effect (describe) _____
<input type="checkbox"/> Patient has failed appropriately dosed recent trial with Copaxone®. Drug _____ Date _____ <input type="checkbox"/> Inadequate response (describe) _____ <input type="checkbox"/> Side effect (describe) _____
<input type="checkbox"/> Other (please specify) _____ _____

All information provided on this form is accurate as of this date.

Provider Signature: _____ **NPI** _____ **Date:** _____

Completed forms should be faxed to: Customer Service Department (866) 423-0945