PARAMOUNT
Affiliate of ProMedica

CRITERIA: PMT
APPROVED: 6/2020
VERIFIED: 7/2020
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Vumerity

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of drug Vumerity.

Brand Name (select from list of drugs shown)

Vumerity (diroximel fumarate)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1	Does the patient have one of the following diagnoses: A) relapsing-remitting multiple sclerosis, B) active secondary progressive multiple sclerosis, or C) clinically isolated syndrome? Please, submit chart notes confirming diagnosis. [If no, no further questions.]	Yes	No
2	Has the drug been prescribed by, or in consultation with, or under the guidance of a neurologist? [If no, no further questions.]	Yes	No

3	Were ALL of the following baseline labs completed within 6 months of the initiation of therapy: A) complete blood count, B) lymphocyte count, C) serum aminotransferase, D) alkaline phosphatase, and E) total bilirubin? Please, submit chart notes for baseline labs. [If no, no further questions.]	Yes	No
4	Will the provider monitor the complete blood count, including lymphocyte count, A) after 6 months of initiation of treatment, B) every 6 to 12 months thereafter AND C) consider interruption of treatment if lymphocyte counts less than 500 cells per microliter persist for more than six months? [If no, no further questions.]	Yes	No
5	Will the provider continue to monitor the patient s serum aminotransferase, alkaline phosphatase, and total bilirubin during treatment as clinically indicated? [If no, no further questions.]	Yes	No
6	Will treatment be discontinued if clinically significant liver injury due to treatment is suspected? [If no, no further questions.]	Yes	No
7	Will the requested drug be withheld at the first sign or symptoms suggestive of progressive multifocal leukoencephalopathy (PML)? [If no, no further questions.]	Yes	No
8	Will the dose exceed a starting dose of 231 milligrams (mg) twice a day, orally, for 7 days and a maintenance dose of 462 mg (two 231 mg capsules) twice a day, orally? [If yes, no further questions.]	Yes	No
9	Will the requested drug be administered with other Multiple Sclerosis disease modifying therapies (DTMs)? [If yes, no further questions.]	Yes	No
10	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
11	Is this a request for continuation of therapy with the requested drug? [If no, no further questions.]	Yes	No

12	Were all of the following labs completed within the previous 6 months: A) complete blood cell count, B) serum aminotransferase, C) alkaline phosphatase, and D) total bilirubin? Please, submit chart notes for labs.	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date