



# Pharmacy Update

Pharmacy Help Desk Phone Numbers (405)522-6205 option 4 or (800)522-0114 option 4  
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PA Criteria: [www.okhca.org/providers/rx/pa](http://www.okhca.org/providers/rx/pa) PA forms: [www.okhca.org/rx-forms](http://www.okhca.org/rx-forms)

February 24, 2012

## Multiple Sclerosis (MS) Medications Prior Authorization

Prior authorization requirements take effect March 7, 2012. Members who are currently taking these medications may continue therapy without prior authorization unless a gap in therapy is indicated in SoonerCare claims history.

**Tier 1 Interferons do not require prior authorization.**

**Tier 2 Interferons Prior Authorization Criteria:**

1. Documented diagnosis of relapsing remitting MS.
2. Tier-2 medications require failure of the preferred Tier-1 product defined as:
  - a. Occurrence of an exacerbation after 6 months.
  - b. Significant increase in MRI lesions after 6 months.
  - c. Adverse reactions or intolerable side effects.
3. No concurrent use with other therapies.
4. Compliance will be checked for continued approval every 6 months.

Tier 1	Tier 2
Interferon $\beta$ - 1a ( <b>Rebif</b> ®)	Interferon $\beta$ - 1a ( <b>Avonex</b> ®)
Interferon $\beta$ - 1b ( <b>Betaseron</b> ®)	Interferon $\beta$ - 1b ( <b>Extavia</b> ®)

**Glatiramer Acetate (Copaxone®) Prior Authorization Criteria:**

1. FDA approved diagnosis.
2. No concurrent use with other therapies.
3. Compliance will be checked for continued approval every 6 months.

**Fingolimod (Gilenya®) Prior Authorization Criteria:**

1. Documented diagnosis of relapsing remitting MS with at least one relapse in the previous 12 months, or transitioning from existing MS therapy.
2. No concurrent use with other therapies.
3. Compliance will be checked for continued approval every 6 months.

**We appreciate the services you provide to Oklahomans insured by SoonerCare.**