Prescriber Criteria Form
Gilenya 2025 PA Fax 620-A v1 010125.docx
Gilenya (fingolimod)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Gilenya (fingolimod).

Drug Name:
Gilenya (fingolimod)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, active secondary progressive MS)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for clinically isolated syndrome?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____