Medical Standards & Governance Pre-approval Form

This is a pre-requisite form provided upon request for the **"Pre-Authorization Form for Multiple Sclerosis Drugs Therapy and Diagnostics"**.

Please ensure all requested fields below are completed. This is a mandatory step to proceed further. Incomplete information may result in delays in processing the applicant's request. Please be aware that the provider will be contacted in case further clarifications are required.

GENERAL INFORMATION

- Member's Name:
  ☐ New ☐ Established
- Date of Birth: / /
- Member's Card No.:
- Policy:
- Gender: ☐ Female ☐ Male
- Request date: / /

PROVIDER INFORMATION

- Provider's Name:
- Ordering Clinician (ID no. & Name):
- Performing Provider Name:
- Performing Clinician Specialty (ID no. & Name):
- Referring Physician (ID no. & Name):

SERVICE REQUESTED

- Principal/Primary Diagnosis:
- ICD-10:
- Requested Procedure/Medication:

MRI Request (Please fill in details if MRI is requested)

- Request type: New MRI MRI repeat
- If repeated, please specify the medical necessity of repetition
- Previous MRI Date:
- Previous MRI Findings:
- Type of MS [RIS, CIS, RRMS, PPMS, SPMS]:

Drug Therapy Request Requirements (Please fill in all requested details) And Prescription copy with the dosing regimen for medication?

1. Please mark the type of request:

☐ Initiation
☐ Refill
☐ Switch

2. Clinical presentation (In case of relapse, please specify symptoms onset and duration):

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3. History of illness:

Onset:

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Presenting Features:

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Other diagnostic tests performed:
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Initial Therapy:
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5. Specify if the medication is first-line therapy or switch/escalation therapy?

First Line:

Yes ☐ No ☐

Switch / escalation Therapy:

Yes ☐ No ☐

6. If there is Switch/ escalation treatment, please specify:

Previous medication name:
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Dosage
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duration
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Justification for escalation
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7. For unlicensed/off-label, please attach off-label committee approval including medication name, strength, dosage and duration, previous medication history, expected outcome, patient's safety concerns, what are the alternatives that will be used, the treatment duration

8. Confirmation of the tests/Conditions below:

- CBC value: normal Yes ☐ No ☐
  if no, please specify the values

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- ESR value: normal Yes ☐ No ☐
  if no, please specify the values

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- LFT values: normal Yes ☐ No ☐
  if no, please specify the values

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- TFT value: normal Yes ☐ No ☐
  if no, please specify the values

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- Vitamin (B12, D…) levels: normal Yes ☐ No ☐
  if no, please specify the values

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- Neurofilament light chain (NfL): normal Yes ☐ No ☐
  if no, please specify the values

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- Various antibodies and markers related to infections and autoimmune conditions: Positive Yes ☐ No ☐
  if no, please specify the values

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- Lumbar Puncture and CSF analysis performed Yes ☐ No ☐
  Results and findings

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- pregnant test for females Positive ☐ Negative ☐

- HIV test Positive ☐ Negative ☐

9. Additional information:

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10. Are 2024 McDonald Criteria met?

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Neurologist's Certification

I hereby certify that the proposed intervention meets medical necessity criteria as per regulator and health authorities' standards and protocols, with conservative therapy failure documented.

Physician's Signature	Date	Printed Name	DOH License #