Louisiana Medicaid
Siponimod (Mayzent®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for siponimod (Mayzent®).

Approval Criteria

- Recipient has a diagnosis of a multiple sclerosis; **AND**
- Siponimod (Mayzent®) is prescribed by, or the request states that the medication is being prescribed in consultation with, a neurologist; **AND**
- **ONE** of the following applies:
    - The prescriber **states on the request** that the recipient is currently using the medication *(current use of the requested medication is not established through use of medication samples, coupons or discount cards)*; **OR**
    - The recipient has had a *treatment failure* with at least one preferred product that is indicated for treatment of multiple sclerosis [see Multiple Sclerosis Agents – Immunomodulatory Agents on the preferred drug list (PDL)]; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product that is indicated for treatment of multiple sclerosis [see Multiple Sclerosis Agents – Immunomodulatory Agents on the PDL]; **OR**
    - The recipient has a *documented contraindication(s)* to all the preferred products that are appropriate to use for the condition being treated [see Multiple Sclerosis Agents – Immunomodulatory Agents on the PDL]; **OR**
    - There is *no preferred product that is appropriate to use for the condition* being treated [see Multiple Sclerosis Agents – Immunomodulatory Agents on the PDL]; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

- Recipient continues to meet all initial approval criteria; **AND**
- The prescriber **states on the request** that the recipient is responding positively to therapy**.**

Duration of initial and reauthorization approval: 12 months

Additional edits may apply at Point-of-Sale (POS). Override options may be available. For more information, refer to the Louisiana Department of Health Pharmacy Benefits Management Services Manual at www.lamedicaid.com/provweb1/Providermanuals/manuals/PHARMACY/PHARMACY.pdf

Reference

Mayzent® (siponimod) [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2019. Retrieved from https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/mayzent.pdf

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