

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Rebif®, Avonex® (interferon Beta-1 a), Betaseron® (interferon Beta-1 b) & Copaxone® (glatiramer acetate): Prior Authorization Request Form: Please respond.

- Please complete the attached Rebif®, Avonex® (interferon Beta-1 a), Betaseron® (interferon Beta-1 b) & Copaxone® (glatiramer acetate) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 04/28/2008

Prior Authorization Request Form



Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Rebif®, Avonex® (interferon Beta-1 a), Betaseron® (interferon Beta-1 b) & Copaxone® (glatiramer acetate) Criteria

- Please select product requested:
 Rebif® Avonex®
 Betaseron® Copaxone®
- Please indicate dispensing location:
 from the pharmacy
 from the physician's supply, incident to a physician's service
 Other _____
- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.
 relapsing forms of multiple sclerosis (safety and efficacy in patients with chronic progressive multiple sclerosis have not been established)(ICD-9: 340)
 Patients with MS who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS (ICD-9: 340).
 Other (diagnosis and ICD-9) _____
- If Rebif® or Betaseron® is requested, has the patient failed to achieve an appropriate response, or demonstrated intolerance to Avonex® or Copaxone® first?
 Yes No
- Are these agents prescribed by a neurologist or has one been consulted?
 Yes No

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____