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

TODAY'S OPTIONS®

Important Information About Prescription Drug Coverage

To: From:

Fax: Pages:

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

- Please complete the attached Rebif®, Avonex® (interferon Beta-1a), Betaseron® (interferon Beta-1b) & 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.

Prior Authorization Request Form

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

TODAY'S OPTIONS®

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

1 Please select product requested:
- ☐ Rebif®
- ☐ Avonex®
- ☐ Betaseron®
- ☐ Copaxone®

2 Please indicate dispensing location:
- ☐ from the pharmacy
- ☐ from the physician's supply, incident to a physician's service
- ☐ Other ....

3 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) ....

4 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

5 Are these agents prescribed by a neurologist or has one been consulted?
- ☐ Yes ☐ No

Medical Justification: (Attach additional page if necessary): ______________________

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Prescriber's signature:______________________ Date:______________