

# Drug Coverage Review Request

Beta Interferons (*Avonex*<sup>®</sup>, *Rebif*<sup>®</sup>, *Betaseron*<sup>®</sup> and *Extavia*<sup>®</sup>)



## SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

### PRESCRIBER

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

### PATIENT

Cardholder ID # \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

## SECTION A Please answer the following questions

- For which situation is this drug being prescribed?
  - Treatment at time of first demyelinating event to delay development or progression to multiple sclerosis
  - Relapsing-remitting multiple sclerosis
  - Secondary-progressive multiple sclerosis
  - Progressive-relapsing multiple sclerosis
  - Primary-progressive multiple sclerosis
  - Other
- Yes  No Is this patient able to walk at least a few steps or, alternatively, have some functional arm or hand use consistent with performing activities of daily living?
- Yes  No Is this patient currently receiving interferon-beta with *Copaxone*?

## SECTION B Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET



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