

Drug Coverage Review Request

Glatiramer Acetate (*Copaxone*[®])

Coverage Review Fax Form



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 glatiramer acetate (*Copaxone*) 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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