

**Prior Authorization Request Form for Multiple Sclerosis
Betaseron/Copaxone/Rebif**

Member Information

Patient Name _____
Cardholder ID _____
Date of Birth _____
Address _____
City, State Zip _____
Phone Number _____

Provider Information

Provider Name _____
DEA Number _____
Address _____
City, State and Zip _____
Phone Number _____
FAX Number _____

Pharmacy Information

Pharmacy Name _____ Address _____ Phone _____

Criteria for Approval:

- 1. MS product requested: *Check one:*
 Betaseron **Copaxone** **Rebif**
- 2. Does the patient have a diagnosis of primary progressive multiple sclerosis? Yes No
- 3. Does the patient have a diagnosis of: *Check one:*
 Secondary progressive multiple sclerosis
 Relapsing-remitting multiple sclerosis
- 4. Is this a new medication therapy or a continuation therapy: *Check one:*
 New
 Continuation – Start Date: _____
- 5. Is this the first clinical episode of multiple sclerosis for this patient? Yes No
- 6. Did the patient receive a magnetic resonance imaging (MRI) scan that showed features consistent with a diagnosis of multiple sclerosis? Yes No

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____
Reference Number _____
Approved / Denied (Circle One) by _____ Date _____
Date/Time Returned to Provider _____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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