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/TimeReceived_____

ReferenceNumber_____

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

FOX Rx Care
We take your coverage personally.