



Multiple Sclerosis Agents Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans Pharmacy Department at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
Requesting Physician: _____ Specialty: _____
(Please print)
Office Contact Person: _____ Phone #: (____)____-____ ext ____
Office Address: _____
Medication/dose Requested: _____ Fax #: (____)____-____
Expected Duration of Therapy: _____ ICD-9: _____

Rebif (interferon beta-1a) and Copaxone (glatiramer acetate) are the preferred agents for the treatment of relapsing-remitting multiple sclerosis (RRMS). For members with a managed formulary, coverage for initial treatment with Avonex or Betaseron will be considered for members that have documented trial/failure to the formulary agents, Rebif or Copaxone.

1. Please indicate the patient's diagnosis:

- | | |
|--|--|
| <input type="checkbox"/> Relapsing-remitting MS (RRMS) | <input type="checkbox"/> Progressive relapsing MS (PRMS) |
| <input type="checkbox"/> Primary progressive MS (PPMS) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Secondary progressive MS with relapses (SPMS) | |

2. What is the requested medication?

- | | |
|---|--|
| <input type="checkbox"/> Avonex (interferon beta-1a) | <input type="checkbox"/> Copaxone (glatiramer acetate) |
| <input type="checkbox"/> Betaseron (interferon beta-1b) | <input type="checkbox"/> Rebif (interferon beta-1a) |

3. Is this an initiation of therapy or a continuation of therapy? NEW CONTINUATION

For continued use, please answer the following:

- | | | |
|--|-----|----|
| a. How long has the patient been on the current medication? _____ | | |
| b. Have the number of clinical relapses decreased or remained stable on current therapy? | YES | NO |
| c. Have the number of lesions on MRI diminished or remained stable on current therapy? | YES | NO |

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only:

Approved Length of Approval _____
 Denied Reason for Denial _____
Reviewer's Signature: _____ Date Reviewed: ____/____/____
Override Entered in Caremark CCMS for _____ - _____ by _____
Office Notified on _____; at _____ am/pm; by _____ spoke to _____