Extavia (interferon beta-1b) Prior Authorization Request Form Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: ______ MEMBER'S FIRST NAME: _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

ST NAME:
TE OF BIRTH:
ATE: ZIP CODE:
1

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ______

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:

PRESCRIBER INFORMATION				
LAST NAME:	FIRST NAME:			
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:			
NPI NUMBER:	DEA NUMBER:			
PHONE NUMBER:	FAX NUMBER:			
STREET ADDRESS:				
CITY:	STATE: ZIP CODE:			
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:			

MEDICATION OR MEDICAL DISPENSING INFORMATION					
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
NEW THERAPY		IF RENEWAL: DATE THERAPY	INITIATED:		
DURATION OF THERAPY (SPECIFIC DATES):					

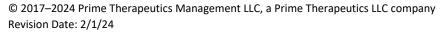
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MEMBER'S LAST NAME:	MEMBER'S FIRST	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO			
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:			
2. LIST DIAGNOSES:		ICD-10:			
 Clinically Isolated Syndrome(CIS) Relapsing remitting multiple sclerosis Secondary Progressive multiple sclerosis Other DiagnosisICD-10 Compared to the sclerosis 	ode(s): : PLEASE PROVIDE ALL RELEVANT CLINIC				
Will patient use in conjunction with a	clinical trial? 🗆 Yes 🛛 🗆 No				
Is the prescribing physician a neurologist? Yes No Has patient had a 3 month trial each of at least 2 of the following? Yes No Please provide documentation. dimethyl fumarate fingolimod glatiramer acetate teriflunomide Has the patient had an inadequate response, intolerance, or contraindication to Betaseron? Yes No					
Reauthorization: If this is a reauthorization request, answer the following question:					
Is the patient continuing to have a positive clinical response and is remission of disease maintained with continued use of Extavia?* Yes No Please provide supporting chart notes.					
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?					
Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.					



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MEMBER'S LAST NAME: _____

MEMBER'S FIRST NAME: _____

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:

Date:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811