# Copaxone (glatiramer)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**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.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

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

**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 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** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES): | | **IF RENEWAL:** DATE THERAPY INITIATED: | |

*Continued on next page.*

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

| **1. HAS THE PATIENT TRIED ANY OTHER 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<br>□ Relapsing remitting multiple sclerosis<br>□ Secondary progressive multiple sclerosis<br>□ Other Diagnosis_____ICD-10 Code(s):_____ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Will patient use in conjunction with a clinical trial? □ Yes □ No**

**Is the prescriber a neurologist? □ Yes □ No**

**Has the patient tried the generic glatiramer acetate product? □ Yes □ No**

**Does patient have an absolute contraindication to the generic glatieramer acetate? □ Yes □ No**
***Please provide supporting chart notes.***

**If the patient has tried the authorized generic glatiramer acetate and will not be continuing it, has a U.S. FDA MedWatch Voluntary Reporting Form for adverse drug reactions (FDA Form 3500) been filed with the FDA?**
**□ Yes □ No *Please submit a copy of the completed FDA 3500 form*.**

**Reauthorization:**
**If this is a reauthorization request, answer the following question:**
**Is the patient continuing to have a positive clinical response and is disease remission maintained with continued use of Copaxone?* □ Yes □ No**
***Chart documentation is required***

**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.

**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:** _____




Revision Date: 2/1/24



Prime THERAPEUTICS™

**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