Prior Authorization Form

MULTIPLE SCLEROSIS (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at **1-888-836-0730**. Please contact CVS Caremark at **1-855-240-0536** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Avonex (interferon beta-1a).

Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group No:

Patient DOB: / /

Prescribing Physician

Physician Name:

Physician Phone: - -

Physician Fax: - -

Physician Address:

City, State, Zip:

Drug Name (specify drug): Avonex (interferon beta-1a)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1. Has the patient received at least a 28-day supply of the requested medication within the previous 120 days in a paid claim through a pharmacy or medical benefit? **Y** ☐ **N** ☐
2. Has the patient tried and had an inadequate response to at least ONE Preferred Product (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio)? *Indicate the name and trial duration of the Preferred Product tried* **Y** ☐ **N** ☐

   _____
3. Has the patient tried and was intolerant to or had confirmed adverse event with at least ONE Preferred Product (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio)? **Y** ☐ **N** ☐
4. Does the patient have a contraindication to at least ONE Preferred Product (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio) or any of its components? **Y** ☐ **N** ☐
5. Has the patient tried and had inadequate responses to at least TWO Preferred Products (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio)? *Indicate the name and trial duration of the Preferred Products tried* **Y** ☐ **N** ☐

   _____
6. Has the patient tried and was intolerant to or had confirmed adverse events with at least TWO Preferred Products (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio)? **Y** ☐ **N** ☐
7. Does the patient have contraindications to at least TWO Preferred Products (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio) or any of their components? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

Prescriber (Or Authorized) Signature and Date

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