Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

MS Agents (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed 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 MS Agents (FA-PA).

Drug Name (select from list of drugs shown)

Avonex (interferon beta-1A)	Avonex Pen (interferon beta-1A)	Avonex Prefilled Kit (interferon beta-1A)
Extavia (interferon beta-1B)	Plegridy (peginterferon beta-1A)	

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. The preferred interferon beta-1b product for your patient's health plan is Betaseron. Can the patient's treatment be switched to Betaseron? Y N

   Please note that Betaseron and Extavia are the exact same products with different labels and brand names, which are made in the same manufacturing facility.

2. The other preferred interferon beta product for your patient's health plan is Rebif. Can the patient's treatment be switched to Rebif? Y N

3.	Given that Betaseron and Extavia are the same products, is there a documented clinical reason that the patient must use Extavia over Betaseron? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date