

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 Extavia (interferon beta-1b).

Patient Information

Patient Name:	<input type="text"/>
Patient Phone:	<input type="text"/>
Patient ID:	<input type="text"/>
Patient Group No:	<input type="text"/>
Patient DOB:	<input type="text"/>

Prescribing Physician

Physician Name:	<input type="text"/>
Physician Phone:	<input type="text"/>
Physician Fax:	<input type="text"/>
Physician Address:	<input type="text"/>
City, State, Zip:	<input type="text"/>

Drug Name (specify drug): Extavia (interferon beta-1b)

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 | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 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)? <i>Indicate the name and trial duration of the Preferred Product tried</i> | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. Has the patient tried and had inadequate responses to at least TWO Preferred Products (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio)? <i>Indicate the name and trial duration of the Preferred Products tried</i> | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | N | <input type="checkbox"/> |

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

Now you can get responses to drug Pas immediately and securely online – without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.