Multiple Sclerosis Interferon Products
Extavia, Plegridy, Avonex, Betaseron, Rebif
HMSACOM - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Multiple Sclerosis Interferon Products HMSACOM C21334-A – 2/2026.

What is the requested product?

- ❑ Extavia, *Continue to Exception Criteria Questions*
- ❑ Plegridy, *Continue to Exception Criteria Questions*
- ❑ Avonex, *No further questions*
- ❑ Betaseron, *No further questions*
- ❑ Rebif, *No further questions*

Exception Criteria Questions:

1. Is the request for Extavia?

❒ Yes, *Continue to question 2*
❒ No, *Continue to question 5*

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

❒ Yes, *No Further Questions*
❒ No, *Continue to question 3*

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).*

❒ Yes, *Continue to question 4*
❒ No, *Continue to question 4*

4. Has the patient experienced a documented inadequate response or an intolerable adverse event to Avonex and Rebif? ***Action Required****: If 'Yes', attach supporting chart note(s).*

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Is the request for Plegridy?

❒ Yes, *Continue to question 6*
❒ No, *Continue to question 8*

6. The preferred products for your patient's health plan are Avonex, Betaseron and Rebif
Can the patient's treatment be switched to a preferred product?

❒ Yes, *No Further Questions*
❒ No, *Continue to question 7*

7. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to treatment with Avonex, Betaseron, and Rebif? ***Action Required****: If 'Yes', attach supporting chart note(s).*

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Has the patient tried and failed treatment with all of the preferred products, Avonex, Betaseron and Rebif? ***Action Required****: If 'Yes', attach supporting chart note(s).*

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

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