

Date of Request _____

Avonex – interferon beta-1a

This Product is a Non-Preferred Agent. Preferred Agents are **Betaseron, Copaxone**. Use of a Non-Preferred agent may result in additional utilization controls as well as increased patient co-pays. Please consider prescribing a Preferred Agent.

Member Information

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth Date _____
 Address _____
 City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
 Gender (Circle)
 Male Female
 AGE: _____

Practitioner Information

Name _____
 Agent / Contact Name _____ Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____
 Phone () - Fax () -
 Email _____ @ _____

Primary Diagnosis Condition / Diagnosis Related – Reason for Request

- Is the patient ambulatory? **Y / N**
- Type of MS:
 - First clinical episode with MRI features consistent with MS
 - Relapsing-remitting MS
 - Secondary-progressive MS
- Is the patient taking any other medications for the treatment of MS? **Y / N**
- If yes, please list the medication(s):

Strength / Dose

Duration of Therapy (Expected)

Formulary Alternatives Attempted/Outcome

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? **Y N**
 Pharmacy Phone Number

Practitioner Signature

Date Received: _____
 Reviewed By: _____
 Forwarded To: _____

**FAX Form to
 877-800-5633**

HealthTrans Prior Authorization
 866-805-1690

Date of Request _____

Betaseron – interferon beta-1b

Thank you for selecting a Preferred Agent

Member Information

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth Date _____
 Address _____
 City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
 Gender (Circle)
 Male Female
 AGE: _____

Practitioner Information

Name _____
 Agent / Contact Name _____ Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____
 Phone () - Fax () -
 Email _____ @ _____

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Strength / Dose

Duration of Therapy (Expected)

Formulary Alternatives Attempted/Outcome

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? **Y N**

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
 Reviewed By: _____
 Forwarded To: _____

**FAX Form to
 877-800-5633**

Date of Request _____

Copaxone – glatiramer acetate

Thank you for selecting a Preferred Agent

Member Information

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth Date _____
 Address _____
 City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
 Gender (Circle)
 Male Female
 AGE: _____

Practitioner Information

Name _____
 Agent / Contact Name _____ Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____
 Phone () - Fax () -
 Email _____ @ _____

Primary Diagnosis Condition / Diagnosis Related – Reason for Request

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- Type of MS:
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- Is the patient taking any other medications for the treatment of MS? **Y / N**
- If yes, please list the medication(s):

Strength / Dose

Duration of Therapy (Expected)

Formulary Alternatives Attempted/Outcome

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? **Y N**

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
 Reviewed By: _____
 Forwarded To: _____

**FAX Form to
 877-800-5633**