HEALTHTRANS

Prior Authorization Request

Date of Request ____________________

Rebif – 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:
  - ☐ 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