



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Copaxone® (glatiramer acetate)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	Physician Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic. Id:
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the requested duration of therapy? 12 months or less Greater than 12 months
Q2. What is the patient's diagnosis? Chronic-progressive Multiple Sclerosis Remitting-Relapsing Multiple Sclerosis Other
Q3. If OTHER, please specify:
Q4. Are there any contraindications to the use of this drug for this patient? Yes No
Q5. What is the patient's age? Less than 18 years Equal to or greater than 18 years
Q6. Deliver to: Physician's Office Home Delivery
Q7. Delivery date needed:

Physician Signature

Date