



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Rebif (Interferon Beta)

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 More than 12 months
Q2. What is the patient's age? Less than 18 years 18 years or older
Q3. Does the patient have a diagnosis of relapsing forms of multiple sclerosis (patients with MS or with clinically isolated syndromes suggestive of MS who are at high risk for developing clinically definite MS)? Yes No
Q4. Has the patient tried and failed both Avonex and Copaxone? Yes No
Q5. Deliver to: Physician's Office Home Delivery
Q6. Delivery date needed:

Physician Signature

Date