

**Copaxone® Prior Authorization Request Form (Page 1 of 2)**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Multiple sclerosis (MS)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Clinical Information:</b>	
Does the patient have a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Quantity Limit Requests:</b>	
What is the quantity requested per MONTH? _____	
<b>What is the reason for exceeding the plan limitations?</b>	
<input type="checkbox"/> Titration or loading dose purposes	
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)	
<input type="checkbox"/> Requested strength/dose is not commercially available	
<input type="checkbox"/> Other: _____	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**



1230 US Highway 11  
Gouverneur, NY 13642  
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

## Copaxone® Prior Authorization Request Form (Page 2 of 2)

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): \_\_\_\_\_ Date: \_\_\_\_\_

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1 <sup>st</sup> Attempt		2 <sup>nd</sup> Attempt		Letter Mailed:	