

## Plegridy® Prior Authorization Request Form (Page 1 of 2)

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
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 <small>(required)</small>					
<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					
Is this request for continuation of Plegridy therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has history of failure following a trial for at least 4 weeks or history of intolerance or contraindication to the following disease-modifying therapies for MS:					
<input type="checkbox"/> Avonex (interferon beta-1a)					
<input type="checkbox"/> Betaseron (interferon beta-1b)					
<input type="checkbox"/> Copaxone (glatiramer acetate)					
<input type="checkbox"/> Tecfidera (dimethyl fumarate)					
<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: _____					

**Plegridy® Prior Authorization Request Form (Page 2 of 2)**

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.**

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: \_\_\_\_\_

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