

Rebif® 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 brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Multiple sclerosis (MS)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
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 Rebif 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)					
Quantity Limit Requests:					
What is the quantity requested per MONTH? _____					
What is the reason for exceeding the plan limitations?					
<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: _____					

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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: _____

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