Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Avonex® (interferon beta 1A)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Avonex 30 mcg vial
- ☐ Avonex 30 mcg prefilled syringe
- ☐ Avonex 30 mcg pen kit

Start date (or date of next dose): _____

Dose Requested: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of relapsing-remitting multiple sclerosis (RRMS), secondary-progressive multiple sclerosis (SPMS), or progressive-relapsing multiple sclerosis (PRMS).
2. Prescriber is board-certified neurologist or multiple sclerosis physician specialist with experience prescribing MS therapy
3. Patient will not be using in combination with another disease-modifying agent for MS.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ RRMS ☐ SPMS ☐ PRMS

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Is the prescriber a neurologist?

☐ Yes ☐ No

C. Will patient be using in combination with another disease-modifying agent for MS?

☐ Yes, *rationale:* _____

☐ No

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 02/2018

Last reviewed 07/2018