



# Avonex / Rebif / Copaxone

## PRIOR AUTHORIZATION REQUEST FORM

Complete *ENTIRE* form and Fax to: 866-940-7328

<b>Today's Date</b>			
<b>SECTION A - PATIENT INFORMATION</b>			
First Name:		Last Name:	Member ID:
Address:			
City:	State:		Zip:
Phone:	DOB:	Allergies:	
Primary Insurance:	Policy #:	Group #:	
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>SECTION B - PHYSICIAN INFORMATION</b>			
First Name:		Last Name:	M.D./D.O.
Address:	City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
<b>SECTION C - MEDICAL INFORMATION</b>			
Medication:			
Directions for use:			
Diagnosis (Please be specific & provide as much information as possible):			ICD-10 CODE:
Does this patient have a diagnosis of relapsing forms of multiple sclerosis? (Check response) <input type="checkbox"/> YES <input type="checkbox"/> NO			
Did the patient have a first clinical episode with MRI features consistent with multiple sclerosis? (Check response) <input type="checkbox"/> YES <input type="checkbox"/> NO			
Additional Clinical Information: _____ _____ _____ _____			

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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URGENT – 24 HOUR

**Specialty Medication Prior Authorization Cover Sheet**

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to [www.uhccommunityplan.com](http://www.uhccommunityplan.com) for medication fax request forms.)

**Patient Information**

Patient's Name: \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Sex:  Male  Female

**Provider Information**

Provider's Name: \_\_\_\_\_ Provider ID Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Suite Number: \_\_\_\_\_ Building Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Provider's Specialty: \_\_\_\_\_

**Medication Information**

Medication: \_\_\_\_\_ Quantity: \_\_\_\_\_ ICD10 Code: \_\_\_\_\_

Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Refills: \_\_\_\_\_

**Physician Signature\*\*:** \_\_\_\_\_ **DAW (Initial here):** \_\_\_\_\_

**Physician Signature\*\*:** By signing above the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

**Medication Instructions**

Has the patient been instructed on how to **Self-Administer**?  Yes  No

Is this medication a **New Start**?  Yes  No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

**\*\*Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed**

**Delivery Instructions**

**Note:** Delivery coordination requires a **"Physician Signature"** above and complete **"Provider Information"** and **"Patient Information"**

**Note:** All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

**Ship to:** Physician's Office  Patient's Address  Date medication is needed: / /

Medication Administered: Home Health  Self Administered  LTC  Physician's Office