

BETASERON (interferon beta-1b)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Betaseron
 2. What is the diagnosis? Multiple Sclerosis Other (specify): _____
 3. Will the patient be using the Betaseron in combination with other biologics (Avonex, Copaxone, Novantrone, Rebif, Tysabri) for Multiple Sclerosis (MS)? Y N
 4. Does the patient have uncontrolled major depression or is the patient suicidal? Y N
 5. Please document or attach the results of liver function tests (LFTs) and complete blood counts (CBC) with differential (i.e., Albumin, Alkaline Phosphatase, ALT, AST, Bilirubin total, Bilirubin direct, GGT)
-
6. Are the LFTs and CBC results within normal limits? Y N
 7. If results are not within normal limits, is the patient symptomatic or do the results necessitate withholding therapy? Y N

