

REBIF (interferon beta-1a)

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? Rebif
2. What is the diagnosis? Multiple Sclerosis Condyloma acuminatum Multifocal motor neuropathy
 Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) Other _____
(specify): _____
3. Will the patient be using the Rebif in combination with other biologics (Avonex, Betaseron, Copaxone, Novantrone, 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

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7. If results are not within normal limits, is the patient symptomatic or do the results necessitate withholding therapy? Y N

8. Which form of MS does the patient have? Primary progressive MS Relapsing-remitting MS
 Secondary progressive MS Progressive relapsing MS

9. Is the patient currently receiving treatment with Rebif for Multiple Sclerosis? Y N
If answer is no, no further questions are required.

10. Has the prescribed medication been effective? Y N
If answer is yes, no further questions are required.

11. Is there a clinical reason for the lack of efficacy? Y N

12. Please document the reason:

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::