PRIOR AUTHORIZATION REQUEST
Glatopa

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:____________ Qty Requested: ____________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Patient has a relapsing form of multiple sclerosis (MS)
   - ☐ Non-relapsing forms of multiple sclerosis (MS)
   - ☐ Other diagnoses or indications – Please specify ____
2. ☐ Yes ☐ No Is the requested medication being prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of multiple sclerosis (MS)?
3. ☐ Yes ☐ No Will the patient be using the requested medication in combination with another disease-modifying agent used for multiple sclerosis [MS]?

Please document the diagnoses, symptoms, and/or any other information important to this review:

____

____

SECTION B Physician Signature

____
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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authorization as per Plan policy and procedures.

If you have any questions, call: 800-753-2851

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