



PRIOR AUTHORIZATION REQUEST

Avonex, Betaseron, Extavia, Copaxone

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for an INITIAL or CONTINUATION of therapy? <input type="checkbox"/> Initial (If checked, go to 7) <input type="checkbox"/> Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication?	Yes	No

**If you have any
questions, call:
1-888-258-8250**

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[If yes, skip to question 7.]

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|----|---|-----|----|
| 4 | <p>Does the patient have a previously approved prior authorization (PA) on file with the current plan?
 [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]
 [If no, skip to question 7.]</p> | Yes | No |
| 5 | <p>Has the patient been established on therapy for at least 3 months?
 [If no, skip to question 7.]</p> | Yes | No |
| 6 | <p>Has documentation been submitted to confirm that the patient has experienced a clinically significant improvement in symptoms with therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation.
 [No further questions.]</p> | Yes | No |
| 7 | <p>What is the indication or diagnosis?
 <input type="checkbox"/> Patient has a relapsing form of multiple sclerosis (MS) [Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]. (If checked, go to 8)

 <input type="checkbox"/> Non-relapsing forms of multiple sclerosis (MS) [Note: An example of a non-relapsing form of MS is primary progressive MS.] (If checked, no further questions)

 <input type="checkbox"/> Other diagnoses or indications (If checked, no further questions)</p> | | |
| 8 | <p>Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred injectable MS agent (Glatiramer, Glatopa), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation.
 [If no, no further questions.]</p> | Yes | No |
| 9 | <p>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)?
 [If no, no further questions.]</p> | Yes | No |
| 10 | <p>Will the patient be using the requested medication in combination with another disease-modifying agent used for multiple sclerosis (MS)?
 [Note: Examples are Avonex, Rebif, Betaseron, Extavia, Copaxone, Plegridy, Lemtrada, Tysabri, Gilenya, Mavenclad, Mayzent, Aubagio, Tecfidera, Ocrevus, Bafiertam, Vumerity, Zeposia, and Kesimpta.]
 [If yes, no further questions.]</p> | Yes | No |
| 11 | <p>Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication?</p> | Yes | No |

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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: 1-833-896-0656

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 authorization as per Plan policy and procedures.

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