



Please complete ALL information below and fax your request to 1-888-671-5285

### Aubagio® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

#### Member Information (required) Provider Information (required)

Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

#### Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

#### Clinical Information (required)

**Select the diagnosis below:**

Multiple sclerosis (MS)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

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**Clinical Information:**

Does the patient have a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)?  Yes  No

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**Quantity Limit Requests:**

What is the quantity requested per DAY? \_\_\_\_\_

**What is the reason for exceeding the plan limitations?**

Titration or loading dose purposes

Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

Requested strength/dose is not commercially available

Other: \_\_\_\_\_

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.