



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

### Avonex® Prior Authorization Request Form

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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)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Multiple sclerosis (MS)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Clinical Information:</b>	
Does the patient have a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Quantity Limit Requests:</b>	
What is the quantity requested per MONTH? _____	
<b>What is the reason for exceeding the plan limitations?</b>	
<input type="checkbox"/> Titration or loading dose purposes	
<input type="checkbox"/> 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)	
<input type="checkbox"/> Requested strength/dose is not commercially available	
<input type="checkbox"/> 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?  
\_\_\_\_\_  
\_\_\_\_\_

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

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