



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

Rebif® 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 generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Multiple sclerosis (MS)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
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	
Is this request for continuation of Rebif therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Select if the patient has history of failure following a trial for at least 4 weeks, contraindication or intolerance to the following disease-modifying therapies for MS:	
<input type="checkbox"/> Avonex (interferon beta-1a)	
<input type="checkbox"/> Betaseron (interferon beta-1b)	
<input type="checkbox"/> Copaxone/Glatopa (glatiramer acetate)	
<input type="checkbox"/> Tecfidera (dimethyl fumarate)	
Quantity Limit Requests:	
What is the quantity requested per MONTH? _____	
What is the reason for exceeding the plan limitations?	
<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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