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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Multiple sclerosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of therapy with Rebif? ❑ **Yes** ❑ **No**

Select if the patient has an inadequate response or inability to tolerate the following alternatives:

- ❑ Avonex
- ❑ Betaseron
- ❑ Glatiramer (Copaxone, Glatopa)
- ❑ Tecfidera
- ❑ Plegridy

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

Is there documentation of the inability to reach the requested dose with commercially available dosage forms? ❑ **Yes** ❑ **No**

Is there documentation the dose requested is medically necessary? ❑ **Yes** ❑ **No**

If YES, please specify: _____

_____

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.