



CONTAINS CONFIDENTIAL PATIENT INFORMATION
Betaseron (interferon beta-1B)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Form with fields for Patient Name, ID, DOB, Date of Rx, Phone, Email, Prescribing Physician, Address, Phone, Fax, Specialty, DEA, NPI, and Email Address.

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Form with checkboxes for Betaseron and 0.3mcg, and lines for directions and quantity.

7. DIAGNOSIS:

Line for entering diagnosis.

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Form with checkboxes for approval criteria: Patient on Betaseron, tried Avonex/Rebif, demyelinating episode, relapsing-remitting MS, secondary progressive MS.

9. PHYSICIAN SIGNATURE

Form with lines for Prescriber or Authorized Signature and Date.

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.