Date _____

restat a Catamaran company

Caterpillar Prescription Drug Benefit

icore HEALTHCARE A Magellan Health Company

PRIOR AUTH CRITERIA- MULTIPLE SCLEROSIS INJECTABLE THERAPY

Prescriber Last Name: _____ ***Prescriber First Name:*** _____

Phone: _____ ***Fax:*** _____ ***NPI#:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____ ***Phone*** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

Primary Diagnosis:

Diagnosis (in words): _____

☐ Relapsing/Remitting Multiple Sclerosis (RRMS) ☐ Clinically Isolated Syndrome (CIS)

Prescriber's Specialty: _____

Clinical Information:

New Therapy: ☐

Has patient tried and failed the following injectable therapies?

If yes, provide dates of therapy and supporting clinical documentation.

a. Avonex ☐ No ☐ Yes Start Date: _____ Stop Date: _____
b. Betaseron ☐ No ☐ Yes Start Date: _____ Stop Date: _____
c. Copaxone 20mg ☐ No ☐ Yes Start Date: _____ Stop Date: _____
d. Copaxone 40mg ☐ No ☐ Yes Start Date: _____ Stop Date: _____
e. Rebif ☐ No ☐ Yes Start Date: _____ Stop Date: _____
f. Extavia ☐ No ☐ Yes Start Date: _____ Stop Date: _____

Continuing Therapy: ☐

If continuing on therapy, is patient receiving adequate response? _____Yes _____No **(please submit chart notes regarding patient's positive clinical response and maintenance.)**

	Day Supply	Refills		Day Supply	Refills
☐ Copaxone 20 mg/mL Syringe Sig. 20mg SC QD ☐ Copaxone 40 mg/mL 12ml Sig. 40mg SC TIW	30		☐ Avonex 30 mcg/0.5mL Syringe Sig. 30mcg IM QW	30	
☐ Rebif 22 mcg/0.5mL Syringe Sig. 22mcg SC TIW	30		☐ Avonex 30 mcg/1.0mL Vial Sig. 30mcg IM QW	30	
☐ Rebif 44 mcg/0.5mL Syringe Sig. 44mcg SC TIW	30		☐ Betaseron 0.3 mg/1.2mL Sig. 0.25mg/1.0 mL SC QOD	30	
☐ Rebif Titration Pack 8.8 mcg/0.2mL Syringe Sig. SC 3x weekly for weeks 1 & 2 22 mcg/0.5mL Sig. SC 3x weekly for weeks 3 & 4	30		☐ Extavia 0.3 mg/1.2mL Sig. 0.25mg/1.0 mL SQ QOD	30	

Prescription Information

Information on this form is accurate as of this date: ___/___/___ Prescriber's Signature _____ ☐ DAW

Prescriber's Address: (REQUIRED) _____

Send or Fax completed form to:
877-722-8329

Restat
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:
877-526-9906

DOCTOR'S NOTE: Caterpillar Prior Authorization forms are located at ***www.CatHealthBenefits.com*** on the "For Providers" tab. Print a new form for each request as forms are updated periodically.

Date 3.13.2014