



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTHORIZATION QUESTIONNAIRE–Multiple Sclerosis (MS) Treatment

**M.D. Last Name:** \_\_\_\_\_ **M.D. First Name:** \_\_\_\_\_

**Physician Phone:** \_\_\_\_\_ **Physician Fax:** \_\_\_\_\_

**Patient** \_\_\_\_\_ **ID#** \_\_\_\_\_ **DOB** \_\_\_\_\_

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

#### PA CRITERIA FOR APPROVAL

1. Specify requested medication:

- Avonex
- Betaseron
- Copaxone
- Extavia
- Rebif

2. Diagnosis:

- Multiple sclerosis (MS)
- Other (please specify) \_\_\_\_\_

3. **(Avonex, Betaseron, and Extavia/Rebif only)** Does the patient have a hypersensitivity to natural or recombinant interferon beta, any other component of the formulation, or to human albumin? Yes    No

4. **(Copaxone only)** Does the patient have a hypersensitivity to glatiramer acetate or mannitol? Yes    No

5. Indicate the Classification of Disease:

- Relapsing/Remitting
- Relapsing/Progressing
- Chronic/Progressive

6. Please indicate:

- New Start
- Continuation of therapy

7. Dose Requested: \_\_\_\_\_

8. Physician Signature or name of person providing answers \_\_\_\_\_

**This medication may be dispensed through a Specialty Pharmacy, please provide the patient's phone number for proper enrollment.**

Patient's phone number: \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
P.O. BOX 758  
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:  
**877-526-9906**