

PREAUTHORIZATION FORM

Extavia®/Betaseron® (Extavia is the Preferred Interferon-beta 1b)
 (Interferon-beta 1b)

Therapeutic use: Treatment of ambulatory patients with relapsing-remitting multiple sclerosis to reduce the frequency of clinical exacerbations.

Preferred Product: Extavia must be tried prior to Betaseron

Quantity Limit: 0.25 mg (3mL) SUBQ every other day

Data: Both the J Code and the NDC for Extavia (J1830 and 00078-0569-12) and Betaseron (J1830 and 50419-0523-35) MUST be submitted when billing in order for the claim to be adjudicated.

Authorization Period: 1 year

Patient's name _____

Patient's ID# [][][][][][][][][] DOB [][] / [][] / [][][][][]

ICD-9 [][][][][][][][][] _____

Physician's name _____

Physician's Ph# ([][][][]) [][][][] - [][][][][] Fax# [][][][] - [][][][][]

Physician's signature _____ Date signed [][] / [][] / [][][][][]

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" or answer the following questions:															
1.	Which medication is being requested? <input type="checkbox"/> Extavia <input type="checkbox"/> Betaseron Extavia must be used before Betaseron. If requesting Betaseron, please list why Extavia can't be used: _____														
2.	Is the prescribing physician a neurologist?		<input type="checkbox"/> Yes <input type="checkbox"/> No												
3.	Has the patient been compliant on another MS drug? If so, please list the other therapies that have been tried in the table below.		<input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1"> <thead> <tr> <th>Name of MS Drug</th> <th>Duration of Therapy</th> <th>Reason for Discontinuation</th> </tr> </thead> <tbody> <tr> <td>a.</td> <td></td> <td></td> </tr> <tr> <td>b.</td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> </tbody> </table>				Name of MS Drug	Duration of Therapy	Reason for Discontinuation	a.			b.			c.		
Name of MS Drug	Duration of Therapy	Reason for Discontinuation													
a.															
b.															
c.															
Extavia or Betaseron will not be approved as a first-line agent															

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.