4646 West Lake Park Blvd
Salt Lake City, UT 84120-8282
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Betaseron®/Extavia®
(Interferon-beta 1b)

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

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

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? ❑ Betaseron ❑ Extavia		
2.	Is the prescribing physician a neurologist?	❑ Yes	❑ 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.	❑ Yes	❑ No

Name of MS Drug	Duration of Therapy	Reason for Discontinuation
a.		
b.		
c.		

Betaseron or Extaiva 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.

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