

Preauthorization Form
Betaseron® (Interferon-beta 1b)

Betaseron (interferon beta-1b) is one of three interferons on the market used to treat multiple sclerosis (MS). Betaseron is FDA-labeled for use in ambulatory patients with relapsing-remitting MS to reduce the frequency of clinical exacerbations. The other two interferons, Avonex® and Rebif® (interferon beta-1a), are FDA-labeled for the treatment of patients with relapsing forms of MS to decrease the frequency of clinical exacerbations and delay the accumulation of physical disability. Copaxone® (glatiramer acetate), a non-interferon, is FDA-labeled for the reduction of the frequency of relapses in patients with relapsing-remitting MS.

- **Chart notes must be attached.**
- Betaseron will **not** be covered as initial therapy in the treatment of MS. Avonex, Rebif, or Copaxone must be used prior to initiating Betaseron therapy.
- Billing code = J1830

Patient's name _____

Patient's ID# - - DOB / /

ICD-9 . , . , _____

Physician's name _____ Specialty _____

Physician's phone # () - Fax # -

Physician's signature _____ Date signed / /

Please check "Yes" or "No" or answer the following questions:															
1.	Is the prescribing physician a neurologist?	[] Y	[] N												
2.	Has the patient been compliant on another MS drug? If so, please list the other therapies that have been tried in the table below. Betaseron will not be approved unless the patient has had ≥ 1 relapse on current therapy.	[] Y	[] N												
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name of MS Drug</th> <th style="width: 30%;">Duration of Therapy</th> <th style="width: 40%;">Reason for Discontinuation</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">a.</td> <td style="padding: 2px;"></td> <td style="padding: 2px;"></td> </tr> <tr> <td style="padding: 2px;">b.</td> <td style="padding: 2px;"></td> <td style="padding: 2px;"></td> </tr> <tr> <td style="padding: 2px;">c.</td> <td style="padding: 2px;"></td> <td style="padding: 2px;"></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.															
	Betaseron will NOT be covered as a first-line agent. Please attach chart notes.														

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.