P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

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? ❑ Extavia ❑ 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?	❑ 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. Extavia or Betaseron will **not** be approved as a first-line agent	❑ Yes	❑ No

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

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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