RxAmerica
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Minnesota Health Care Programs Prior Authorization Request Form
Betaseron® (interferon beta-1b)

● ● ●Only one medication request per form ●●● All fields must be complete and legible for review ●●●

☐ STANDARD REVIEW (72 HOURS)	☐ EXPEDITED REVIEW (24 HOURS)
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.	
PATIENT INFORMATION	**PRESCRIBER INFORMATION**
Patient Name:	Prescriber Name and Specialty:
Member ID#:	DEA #:
Sex (circle): Male Female	Office Phone:
Date of Birth:	Office Fax:
Patient Phone:	Contact Person:

PHARMACY INFORMATION			
Pharmacy Name:	NABP#:	PHARMACY PHONE NO:	PHARMACY FAX NO:

DIAGNOSIS AND MEDICAL INFORMATION		
Medication:	Strength and Route of Administration:	Frequency:
☐ New Prescription – OR – Date Therapy Initiated: / /	Expected Length of Therapy:	Quantity:
Height & Weight:	Drug Allergies:	Diagnosis Related to Medication Requested:

Rationale for Prior Authorization Request

Medical Justification for Betaseron:

1. Does the patient have a current diagnosis of relapsing-remitting multiple sclerosis?

   ☐ YES ☐ NO

2. Does the patient have a diagnosis of progressive multiple sclerosis and is currently on Betaseron?

   ☐ YES ☐ NO

Prescriber's Signature:	Date:

Effective Date:11/1/08