



RxAmerica
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**Medicare Part D Prior Authorization Request Form
 Avonex® and Rebif® (interferon beta-1a)**

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

<input type="checkbox"/> STANDARD REVIEW (72 HOURS)		<input type="checkbox"/> 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:	
<input type="checkbox"/> 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 Avonex, Rebif:			
1. Does the patient have a current diagnosis of relapsing-remitting multiple sclerosis?			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
2. Does the patient have a diagnosis of progressive multiple sclerosis and is currently on Avonex or Rebif?			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Prescriber's Signature:		Date:	

