

## Betaseron (interferon beta-1b) Prior Authorization Request Form

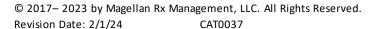


Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

	☐ URGENT		
MEMBER INFORMATION			
LAST NAME:	FIRST NAME:		
PHONE NUMBER:	DATE OF BIRTH:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
PATIENT INSURANCE ID NUMBER:			
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES:  IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: https://magellanrx.com/member/external/commercial/common/doc/en-us/phi disclosure authorization.pdf  PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):			
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:			
PRESCRIBER INFORMATION			
LAST NAME:	FIRST NAME:		
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:		
NPI NUMBER:	DEA NUMBER:		
PHONE NUMBER:	FAX NUMBER:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH: FREQUENCY:	LENGTH OF QUANTITY: THERAPY/REFILLS:		
	IF RENEWAL: DATE THERAPY INITIATED:		
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.



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MEMBER'S LAST NAME:	MEMBER'S FIRST	NAME:
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<ul> <li>□ Clinically Isolated Syndrome(CIS)</li> <li>□ Relapsing remitting multiple sclerosis</li> <li>□ Secondary Progressive multiple sclero</li> <li>□ Other DiagnosisICD-1</li> </ul>	sis 0 Code(s):	
Is drug going to be used in conjunction	on with a clinical trial? ☐ Yes ☐ No	
Is the prescribing physician a neurologous Has patient had a 3 month trial each dimethyl fumarate fingolimod glatiramer acetate teriflunomide	ogist?	No Please provide documentation.
Reauthorization:  If this is a reauthorization request, as	nswer the following question:	
	sitive clinical response and is remission	of disease maintained with continued
Are there any other comments, diagn physician feels is important to this re		ailed, and/or any other information the
Please note: Not all drugs/diagnosis a information is received.	re covered on all plans. This request ma	y be denied unless all required

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## **Betaseron (interferon beta-1b) Prior Authorization Request Form**



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MEMBER'S FIRST NAME:

MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.			
Prescriber Signature or Electronic I.D. Verification:	Date:		
you are not the intended recipient, you are hereby notified that any o	nission contain confidential health information that is legally privileged. If disclosure, copying, distribution, or action taken in re liance on the contents aformation in error, please notify the sender immediately (via return FAX)		

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811

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