



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
 Fax: 1-866-374-1579

**Avonex, Betaseron, Extavia, Rebif**  
**Prior Authorization Request**

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_

1. What drug is being prescribed?  Avonex  Betaseron  Extavia  Rebif  Other \_\_\_\_\_
2. What is the prescribed: Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
3. What is the diagnosis?  
 Multiple Sclerosis (MS)  Clinically-isolated syndrome (CIS)  Other \_\_\_\_\_
4. Will prescribed agent be used as monotherapy?  Yes  No
5. Is the patient currently receiving treatment with prescribed agent? *\*If Yes, skip to #9*  Yes  No
6. Is this the first clinical episode (CIS)?  Yes  No *\*If No, skip to # 8*
7. Has CIS been confirmed by MRI with MS features?  Yes  No
8. Which form of MS does the patient have?  
 Primary progressive MS  Relapsing - Remitting MS  
 Secondary progressive MS **with relapse**  Progressive relapsing MS

*Only answer below questions if patient is currently on therapy.*

9. Has the prescribed medication been effective?  Yes  No
10. If No, is there a clinical reason for lack of efficacy?  Yes  No
11. **FAX COPY of clinical** and document clinical reason for lack of efficacy: \_\_\_\_\_

**\*\*NOTE: We can NOT make a decision without a copy of the results - Thank You\*\***

*Information given on this form is accurate as of this date:*

**X** \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

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