



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

Copaxone

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 copy 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? Copaxone, Dose: _____ Frequency: _____
 Other _____
2. What is the diagnosis? Multiple Sclerosis (MS) Clinically-isolated syndrome (CIS)
 Other _____
3. Will Copaxone be used as monotherapy? Yes No
4. Is the patient currently receiving treatment with Copaxone? **If Yes, skip to # 8* Yes No
5. Is this the first clinical episode (CIS)? Yes No **If No, skip to #7*
6. Has CIS been confirmed by MRI with MS features? Yes No
7. Does the patient have relapsing-remitting MS (RRMS)? Yes No

Only answer below questions if patient is currently on therapy

8. Has Copaxone been effective? Yes No
9. If No, is there a clinical reason for lack of efficacy? Yes No
10. **FAX COPY of clinical** and document clinical reason for lack 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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