

Sterling Retiree Rx Prior Authorization Form

REBIF (Interferon beta-1a) Prescriber must be Neurologist

Coverage Criteria / Required Medical Information:

MRI has been performed and has features suggestive of MS (evidence of lesion).

Re-Authorization Criteria:

Patients with previous use (≥ 12 months) of Rebif must demonstrate 1 of the following clinical responses: decrease in the frequency of relapses; slowing of disease progression; MRI lesions have diminished with therapy **or** patient is stable on therapy.

Exclusion Criteria:

Human albumin sensitivity; concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Betaseron or Extavia); glatiramer acetate **or** mitoxantrone.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

REBIF	Reason for Request		
Condition/Diagnosis Related			

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage
Formulary Alternative(s) Attempted?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Please List Alternative Formulary Drugs	

Comments	
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Physician Signature: _____

Fax Form to 1-866-481-3704