

Bravo Health

Coverage Review / Prior Authorization Request Form

Multiple Sclerosis Therapy

Interferon-Beta (Avonex®, Rebif®, Betaseron®), Copaxone®



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	
Diagnosis and Medication Requested			
Medication Requested (dosage, frequency):		Qty:	
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:	
Clinical Criteria			
Please answer the following questions:			
1. Please indicate if patient is diagnosed with Primary Progressive, Secondary Progressive, Relapsing- Remitting, or Progressive- Relapsing Multiple Sclerosis (MS)?			
<input type="checkbox"/> _____			
2. Does the patient have some functional arm/hand use consistent with performing activities of daily living?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			
3. Is the patient able to walk at least a few steps?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No, patient is unable to walk			
4. How is this medication going to be administered?			
<input type="checkbox"/> Self-administered (or home-administered by family member)			
<input type="checkbox"/> Administered by physician or nurse in office AND physician supplying medication			
Additional Comments/Explanation:			
Request for Expedited Review			
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING 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			

Prescriber's Signature: _____

Date: _____

Fax back to: 866-464-0709

For info call: 877-813-5595

For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>