



Copaxone (glatiramer)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: Last Name, First Name, Prescriber's Name, Specialty, Home Phone, Work Phone, Office Phone, Office Fax, Home Address, City, State, ZIP, Address, City, State, ZIP, SCAN ID number, Date of Birth, Est. Start Date, Office Contact, For Specialty Medications Only: Shipping Address (if different from home address) [] Physician [] Home, Special Instructions (i.e. Non-English Speaking Patient, etc.):

Medication: _____ Diagnosis: _____
Sig: _____ Qty: _____ Refills: _____ ICD 9 Code: _____

Secondary/ Supplemental Insurance Company Phone Name of Insured ID Number Group Number

1. Is the diagnosis or indication for relapsing multiple sclerosis?
2. Is the prescription written by a Neurologist or Multiple Sclerosis Specialist?
3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

For Internal Use Only
[] Approved [] Denied Reviewer's Initials _____ Decision Date _____
Comments _____

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.