



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 Copaxone one of the following?
a. Treatment of patients who have experienced a first clinical episode and have magnetic resonance imaging features consistent with Multiple Sclerosis
b. Reduction of the frequency of relapses in patients with Relapsing-Remitting Multiple Sclerosis?
2. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?

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

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