



**Betaseron**  
(interferon beta-1b)  
**Prior Authorization Form**

**Express Scripts**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

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	
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> 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
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<p><b>1. Is the diagnosis or indication for the treatment of relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations?</b></p>
<p><b>2. Is the prescription written by a Neurologist or Multiple Sclerosis Specialist?</b></p>
<p><b>3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b></p>

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<u>For Internal Use Only</u> <input type="checkbox"/> Approved <input type="checkbox"/> Denied Reviewer's Initials _____ Decision Date _____ Comments _____
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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>.