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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Copaxone

Prior Authorization of Benefits (PAB) Form
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-474-3341

1. PATIENT INFORMATION	**2. PHYSICIAN INFORMATION**
	Prescribing Physician: ______________
Patient Name: ______________	Physician Address: ______________
Patient ID #: ______________	Physician Phone #: ______________
Patient DOB: ______________	Physician Fax #: ______________
Date of Rx: ______________	Physician Specialty: ______________
Patient Phone #: ______________	Physician DEA: ______________
Patient Email Address: ______________	Physician NPI #: ______________
	Physician Email Address: ______________

3. MEDICATION	**4. STRENGTH**	**5. DIRECTIONS**	**6. QUANTITY PER 30 DAYS**
Copaxone	______________	______________	Specify: ______________

7. DIAGNOSIS: ______________

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Is the medication being provided and billed at the physician's office?
☐ Yes ☐ No Is the patient 18 years of age or older?
☐ Yes ☐ No Does the patient have a diagnosis of multiple sclerosis (MS) in the last 730 days?
☐ Yes ☐ No Does the request exceed the maximum recommended daily dose*?

*The maximum recommended daily dose for Copaxone 20mg/ml: limit of 1ml/day (equivalent to 30ml per 30 days) and for Copaxone 40mg/ml: limit of 0.43ml/day (equivalent to 12ml per 28 days)

9. PHYSICIAN SIGNATURE

______________ ______________
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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