MC-Rx
Powered by ProCare Rx

Multiple Sclerosis

Ticket #: ______________________ **Request Date:** ______________________ **Request Time:** ______________________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of a drug on our prior authorization list. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days' Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information)

1. Is the patient currently treated with the requested medication? YES NO

   If yes, when was the treatment with the requested medication started? ______________________

2. Is the prescriber a neurologist or has consulted with a neurologist? YES NO

3. Does the patient have any of the following? (check all that apply)
   - ☐ Current pregnancy (if applicable)
   - ☐ History of autoimmune condition involving the liver
   - ☐ Hepatic disease or hepatic impairment, including ALT or AST at least twice the ULN

4. Has the patient tried the below medications? Approximate Date(s) of Therapy:

   Copaxone YES NO __________________to ___________________

   Gilenya YES NO __________________to ___________________

   Additional Medications (Please list all medication the patient has previously tried and failed for treatment of this diagnosis):

   ________________________________ __________________to___________________

   ________________________________ __________________to___________________

   ________________________________ __________________to___________________

5. Please submit relevant progress/encounter notes.

Authorized Medical Signature:	
Telephone:	**Date:**

<u>When Completed Return To</u>:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.