



Department of Vermont Health Access
Multiple Sclerosis Self Injectables
PRIOR AUTHORIZATION REQUEST

MSSELFINJEC.1
 FORM#19
 C:2.16

PATIENT INFORMATION

Last Name First Name Middle Initial

Allergies: NKA or _____

Street Address City

State County Zip Code

Home Phone Cell Phone

Parent/Guardian Day Telephone Night Telephone

PRESCRIBER'S INFORMATION

Prescriber's Name NPI Number DEA Number

Telephone Number Fax Number Hospital/Clinic Name

Street Address City

State County Zip Code

Contact Person at Office Prescriber Specialty

Please Fax Completed for to:
Fax Number 1-800-218-3221
Phone Number 1-866-843-3604



Patient Diagnosis:

List previous medications/therapies tried and failed for this condition:

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments:

Product:

- Copaxone (Glatiramer) 40 mg/ml Prefilled Syringe (12 per carton)
- Extavia (Interferon beta-1b) 0.3 mg Prefilled Syringe (15 per carton)
- Glatopa (Glatiramer) 20mg/ml Prefilled Syringe (30 per carton)
- Plegridy (Peginterferon beta-1a) Starter Pack **PEN** (63 mcg/0.5ml x 1 dose and 94 mcg/ml x 1dose) **(Therapy initiation ONLY- NO refills)**
- Plegridy (Peginterferon beta-1a) Prefilled **PEN** 125 mcg/0.5ml (2 per carton)
- Plegridy (Peginterferon beta-1a) Starter Pack **SYRINGE** (63 mcg/0.5ml x 1 dose and 94 mcg/ml x 1dose) **(Therapy initiation ONLY- NO refills)**
- Plegridy (Peginterferon beta-1a) Prefilled **SYRINGE** 125 mcg/0.5ml (2 per carton)

(Please Note: This form not to be used for Tysabri PA request or ordering)

Quantity: Refills:

Dose/Route/Frequency Instructions (Sig):

Deliver product to: Patient's home MD office Clinic
 Needles/syringes: quantity sufficient for drug supply with refills as above
Prescriber's Signature: _____ **Date:** _____