aetna®

Copaxone® or Glatopa™ (glatiramer acetate) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☑ Start of treatment: Start date 12 / 25 / 1215
☑ Continuation of therapy: Date of last treatment 12 / 12 / 1216

Precertification Requested By: sd.knfsdmf nsdnsndfnsdfnsdkljf Phone: (545) 645-6454 Fax: (564) 564-5646

A. PATIENT INFORMATION

First Name: 45654sgd564s6d54	Last Name: 523d65gd65sdg654		
Address: kjsDNfsdzkjnfkljdngkjdnkjlnsdknfsdknfskljdhfffffffffdnfkjsndsagagagaga	City: SKbdhakjsbdkjabshabdshjabdsj	State: kl	ZIP: 21544
Home Phone: (987) 987-6987	Work Phone: (564) 564-5644	Cell Phone: (564) 564-5644	
DOB: 12/25/2017	Allergies: nbsldcfjnasdlnfanjsdlknsddddddddddddddddglk;sjasfd;glkjs;dlkj	Email: kljdnfaskjdnfkljsndfnsdfkljnfdjdjdjdjdjdjdjdjdjdjc	

Current Weight: 1245614564 lbs or 54646456 kgs Height: 56456456 inches or 45645645 cms

B. INSURANCE INFORMATION

Aetna Member ID #: 4,smnc/lsdmkf/smdfklms
Group #: kljdncka dsklmadmalsdmkasmdklm
Insured: klmsdkasmdklmasdmadmasdmkkgaskdagj;lkjsa

Does patient have other coverage? ☑ Yes ☑ No
If yes, provide ID#: 564dfh654df65h465 Carrier Name: 654h6s5d4h6g54sd65g46s5d4g65s4g6
Insured: 654ghd654sa6d5g46s5dg465s4dag65465465g465a465g4d6s5fh46d5sf4h65sdf46h5d4sf

Medicare: ☑ Yes ☑ No If yes, provide ID #: dfdsfh;lkl;sfdkh;ldskf;lsdh' **Medicaid**: ☑ Yes ☑ No If yes, provide ID #: hdsflk'd;lfsk'lhk;dslfhk';dsl

C. PRESCRIBER INFORMATION

First Name: zdcf.dns.fnsdf.lknsd.mfns.n		Last Name: .kjnndf.sm ndf. nas.dn ads		*(Check One):* ☑ M.D. ☑ D.O. ☑ N.P. ☑ P.A.	
Address: d,sjhbad.nasdkljnasdnnsakjnsdkajdnsgasdlkgjsl;d		City: .AHJSNalnsKLJNASkjnas		State: kl	ZIP: 65565
Phone: (456) 465-4654	Fax: (545) 456-4564	St Lic #: +6dhf5+d6sf	NPI #: 6+5hg+6s5dg+	DEA #: +6s5gd+6s5dg	UPIN: zsxdasdasd
Provider Email: asdgja;lksdg jlkasjdl; gkjassgd;ldkgj;alskdjc		Office Contact Name: fhdsjlfdskkkh;kdsfj;lkhsdfj;klhsdfj;lkhsdjf;lkj		Phone: (325) 456-1456	

Specialty *(Check one)*: ☑ **Neurologist** ☑ **Primary Care** ☐ **Other**: lkd;ffjfjsk; hjs;lkdfj ;lkhdsjf;l hkjds;lfkhjsl;dkhjk;ldhj;lkdjhlk;sdjf;klhsdjflhksdj;lfh jsdlf

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☑ Self-administered ☑ Physician's Office
☑ Outpatient Infusion Center Phone: (354) 651-4564
Center Name: lk;dfsjl;k hjjjjjjjjjjjjjjjjjjjjjjjjjjjslk d;jhlk;sd fjhk;lsdfjh;lksdfj k;lhsdf
☑ Home Infusion Center Phone: (564) 654-5644
Agency Name: l;kjds flk;hjd;lskfj;lkh sdjf;lhkdjsf;lkjl;ksdfjgl;ksdfjglk;sdfjgl;kf
☑ Administration code(s) (CPT): l;kjgdsa l;kgjas;lkdgj;laksdjgl;kasjd;lgkjas;lkdgjl
Address: lk;gdjas; lkgja;slkdgj l;kasdjg;lkasdjgl;kasdjglksadjgl;ksadjglkasdjglk;asdj;l

Dispensing Provider/Pharmacy: *Patient Selected choice*
☑ Physician's Office ☑ Retail Pharmacy
☑ Specialty Pharmacy ☑ Mail Order
☑ Other: lkjsdag ;lksajdglk jas;ldk gj;alskd gjl;aksd jg;laskd jg;lkasdjgl;l
Name: kljfa ds;lkg jas;lkdg jlaks; dgjl;kasdjglk;asdjg;lkasjdg;lkasjdl;kgja
Phone: (654) 654-6545 Fax: (354) 561-4564
Address: da gjl;aksjdg;lkasdj g;lkajs;dlgkjas;ldkgja;lskdgjl;ksadjg;lksdjg;l
TIN: lkjga l;kgj;laksdjg ;lkasjd;g lkjas;dl; PIN: 5465145646546544546

E. PRODUCT INFORMATION

Request is for ☑ **Copaxone** ☑ **Glatopa: Dose:** dsafhhsdf6hsd+6f5h6+5+ **Frequency:** s+6ag5+sa65dg+6sad5g+6

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: 6+a5g+6asd5g+a6sd5g+6as Secondary ICD Code: +65fgah+65as+d6g5s+6dg5+6 Other ICD Code: +6sadg5a+65g+6asd5g+6a5s+

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For *All* Requests:

Please indicate the type of multiple sclerosis the patient has been diagnosed with:
☑ Relapsing-remitting MS ☑ Secondary-progressive MS ☑ Primary-progressive MS ☑ Progressive-relapsing MS

☑ Yes ☑ No Has the patient been diagnosed with Clinically Isolated Syndrome (CIS)?
→ ☑ Yes ☑ No Has the patient experienced signs and symptoms of clinically isolated syndrome suggestive of MS (i.e., patients who have experienced a first clinical episode and have MRI features consistent with MS)

☑ Yes ☑ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?

For *Copaxone 20 mg* Requests:

☑ Yes ☑ No Has the patient had a documented failure of an adequate trial of Glatopa?
→ ☑ Yes ☑ No Does the patient have an intolerance to Glatopa?
→ ☑ Yes ☑ No Does the patient have a contraindication to Glatopa?
→ Please indicate which of the following describe the evidence of treatment failure:
- ☑ The patient has increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression)
- ☑ The patient has lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions)
- ☑ The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings)
- ☑ Other (please explain): hds;lfkh'l;sd';lfh k'dls;fdhfdf k''''hh;lkds'lfhk'l;fdshk'sd;l k'hlsdk'flh;ks'dfl;hk'dlf;shk'lfd;skh'd;slfkh'ds;lfk'hsd'f;hk'sc

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For Medicare Advantage Part B:
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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
45654sgd564s6d54	523d65gd65sdg654	(987) 987-6987	12/25/2017

G. CLINICAL INFORMATION *Continued* – Required clinical information must be completed in its entirety for all precertification requests.

For *Continuation* requests:

☑ Yes ☑ No Is this continuation request a result of the patient receiving samples of glatiramer acetate (Copaxone/Glatopa)? (Sampling of glatiramer acetate (Copaxone/Glatopa) does not guarantee coverage under the provisions of the pharmacy benefit)

☑ Yes ☑ No Is there clinical documentation supporting disease stability?

☑ Yes ☑ No Is there clinical documentation supporting disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** 12 / 23 / 3213

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.