aetna®

Extavia® (interferon beta-1b) 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 ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Neurologist** ☐ **Primary Care** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
Address: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for ☐ **Extavia: Dose:** _____ **Frequency:** _____

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

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

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 (RRMS) ☐ Secondary-progressive MS (SPMS) ☐ Primary-progressive MS (PPMS)
☐ Progressive- relapsing MS (PRMS)

☐ 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 *Initiation* requests:

How many of the following medications has treatment been ineffective, not tolerated or contraindicated:
Aubagio, Avonex, Betaseron, Gilenya, Glatopa 20 mg or Copaxone 40 mg, Lemtrada, Plegridy, Rebif, Tecfidera? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated or contraindicated:
☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

Please identify if treatment with medication was ineffective, not tolerated or contraindicated:

☐ Ineffective ☐ Not tolerated ☐ Contraindicated

→ 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): _____

Please indicate the ***second*** medication that has been ineffective, not tolerated or contraindicated:

☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera

Please identify if treatment with medication was inffective, not tolerated or contraindicated:

☐ Ineffective ☐ Not tolerated ☐ Contraindicated

→ 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): _____

Please indicate the ***third*** medication that has been ineffective, not tolerated or contraindicated:

☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera

Please identify if treatment with medication was inffective, not tolerated or contraindicated:

☐ Ineffective ☐ Not tolerated ☐ Contraindicated

→ 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): _____

For *Continuation* requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Extavia? (Sampling of Extavia 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:** ____/____/____

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.