



Rebif® (interferon beta-1a) 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:			Phone:
Specialty (Check one): <input type="checkbox"/> Neurologist <input type="checkbox"/> Primary Care <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: <i>Patient Selected choice</i>			
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Retail Pharmacy		
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy	<input type="checkbox"/> Mail Order		
Center Name: _____		<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Home Infusion Center	Phone: _____	Name: _____			
Agency Name: _____		Phone: _____ Fax: _____			
<input type="checkbox"/> Administration code(s) (CPT): _____		Address: _____			
Address: _____		TIN: _____ PIN: _____			

E. PRODUCT INFORMATION

Request is for Rebif: 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 Secondary-progressive MS Primary-progressive MS Progressive-relapsing MS

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

For Continuation requests:

Yes No Is this continuation request a result of the patient receiving samples of Rebif (Sampling of Rebif 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.