OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Rebif® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

❑ Multiple sclerosis (MS)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)? ❑ **Yes** ❑ **No**

Is this request for continuation of Rebif therapy? ❑ **Yes** ❑ **No**

Select if the patient has history of failure following a trial for at least 4 weeks, contraindication or intolerance to the following disease-modifying therapies for MS:

- ❑ Avonex (interferon beta-1a)
- ❑ Betaseron (interferon beta-1b)
- ❑ Copaxone/Glatopa (glatiramer acetate)
- ❑ Tecfidera (dimethyl fumarate)

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.