



**BlueCross BlueShield
of North Carolina**

**DISEASE-MODIFYING DRUGS FOR MULTIPLE SCLEROSIS
GLATIRAMER ACETATE (Copaxone), FINGOLIMOD (Gilenya)
BETA INTERFERON (Betaseron, Extavia, Avonex, Rebif)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

Drug Requested: _____ **Dx Code:** _____

Please answer the following questions:

- For which of the following situations is beta interferon, glatiramer acetate or fingolimod being prescribed?
 - Relapsing-remitting multiple sclerosis
 - Secondary-progressive multiple sclerosis
 - Progressive-relapsing multiple sclerosis
 - Primary-progressive multiple sclerosis (coverage not authorized)
 - Treatment at time of first demyelinating event to delay development or progression to multiple sclerosis
- Is this patient able to walk at least a few steps with or without aid or alternatively, have some functional arm/hand use consistent with performing activities of daily living? Yes No
- Will this patient be receiving concurrent therapy with two or more of the disease-modifying drugs for multiple sclerosis listed above? Yes No

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403