

Prescriber Criteria Form

Interferon 2026 PA Fax 543-A v1 010126.docx  
Betaseron, Extavia (interferon beta-1b), interferon beta-1b  
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Interferon.

Drug Name (select from list of drugs shown):

**Patient Name:**

**Patient ID:**

**Patient DOB:** **Patient Phone:**

**Prescriber Name:**

**Prescriber Address:**

**City:** **State:** **Zip:**

**Prescriber Phone:** **Prescriber Fax:**

**Diagnosis:** **ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Does the patient have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, active secondary progressive MS)? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for clinically isolated syndrome?	Yes	No

Comments: \_\_\_\_\_

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_