



Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment		Phone Number ()	
BILLING DATA	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

INDICATION / DIAGNOSIS

Relapsing Forms of MS Other Indication

DRUG INFORMATION

<input type="checkbox"/> AMPYRA® <input type="checkbox"/> GILENYA® <input type="checkbox"/> TYSABRI® <input type="checkbox"/> OTHER _____	<input type="checkbox"/> Initial Request (new start) <input type="checkbox"/> Continuation Request <input type="checkbox"/> Yes <input type="checkbox"/> No If continuation, did patient receive positive treatment response? If yes specify: _____ If continuation, list start date of last series: _____	Anticipated Start Date
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CLINICAL INFORMATION (Check ALL that apply)

Yes No Has patient had a previous trial of other biologics to treat the condition? If yes, specify dosage _____

<input type="checkbox"/> AVONEX® <input type="checkbox"/> BETASERON® <input type="checkbox"/> COPAXONE®	<input type="checkbox"/> NOVANTRONE® <input type="checkbox"/> REBIF® <input type="checkbox"/> TYSABRI®	<input type="checkbox"/> OTHER _____
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Yes No Is the physician registered with the TOUCH program (TYSABRI only)

Yes No Is TYSABRI being prescribed in conjunction with other biologics to treat MS (e.g. Avonex, Betaseron, Copaxone, etc.)

Yes No Has patient demonstrated an improvement in walking? (AMPYRA only)

Yes No Is the patient able to walk 25 feet without resting? (AMPYRA only)

Yes No Does the patient does have a history of seizures?

Yes No Does the patient have normal renal function (CrCl greater than or equal to 50 ml/min)?

Yes No Will the patient be receiving the drug in the physician's office? If no, list name of servicing provider/facility:

PHYSICIAN SIGNATURE	DATE
Prescribing Physician _____	_____

Note: Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed