Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Authorization for Copaxone (Glatiramer acetate)

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met BCBSVT/TVHP will authorize coverage of Copaxone (Glatiramer acetate). Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _______________ Patient Name: ___________________________

Member ID#:___________________ Date of Birth: _____________________________

Provider Name:_________________ Provider Phone: __________________________

Provider Fax: _____________________ PCP Name: ______________________________

INDICATIONS FOR USE	YES	NO
Initial therapy ☐ Renewal of existing therapy ☐ Answer question 2 and 5		
1. Patient is diagnosed with clinically definite multiple sclerosis (relapsing-remitting or relapsing-progressive) by a neurologist as defined below: If Yes, continue to 1a	☐	☐
a) Two occurrences of a symptom(s) or neurologic dysfunction each lasting a minimum of 24 hours with a symptom-free period of at least one month between occurrences and evidence of two separate signs of neurological dysfunction on clinical exam; or	☐	☐
b) Occurrences of a symptom(s) of neurologic dysfunction each lasting a minimum of 24 hours with a symptom-free period of at least one month between occurrences, and evidence of one sign of neurological dysfunction on clinical exam and supporting evidence of another separate lesion.	☐	☐
2. Classification of Disease (check one): ☐ relapsing/remitting ☐ relapsing/progressing ☐ chronic/progressive		
3. Patient currently has active MS, defined as at least two acute exacerbations within the previous two years.	☐	☐
4. Document dates and nature of exacerbations during the past two years:		
5. General description of functional status: (e.g. Is member able to fulfill activities of daily living without assistance? Is member able to ambulate?)		
6. Does patient have a hypersensitivity to mannitol?	☐	☐
7. Will Prescription be dispensed at (circle one): Provider Office Network Pharmacy		

MEDICATION WILL ONLY BE DISPENSED IN 30 DAY SUPPLIES

Dose: _________ Frequency: __________ Duration of Therapy: __________

PRESCRIBER SIGNATURE_______________________________________ DATE______________

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

BlueCross BlueShield of Vermont
Independent Licensees of the Blue Cross and Blue Shield Association.