

Prescription & Enrollment Form Multiple Sclerosis



(800) 962-6339 Office
(866) 755-6339 Fax

Patient Information

Last Name		First Name	
Social Security #		Date of Birth	
Parent or Guardian			
Home Phone		Other Contact Phone	
Home Address			
City, State, Zip			

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)

<input type="checkbox"/> 340 Multiple Sclerosis	<input type="checkbox"/> Other ICD 9
Patient Weight lb/kg	Patient Height
Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies:
Date of diagnosis	

PRESCRIPTION INFORMATION

<input type="checkbox"/> Avonex® (Interferon beta-1a) 30mcg/QW Prefilled Syringe or vial	Directions:	Qty:
		Refills:
<input type="checkbox"/> Betaseron® (Interferon beta-1b) 25mg/QOD	Directions:	Qty:
		Refills:
<input type="checkbox"/> Copaxone® (Glatiramer acetate) 20mg/QD	Directions:	Qty:
		Refills:
<input type="checkbox"/> Rebif® (Interferon beta-1a) <input type="checkbox"/> 22mcg <input type="checkbox"/> 44mcg	Directions:	Qty:
		Refills:

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

SUPPLIES NEEDED (if medication is to be administered in the patient's home):

If checked, please specify the size and type (if applicable):

- Syringes/Needles Swabs Sharps Container Other

DELIVERY INSTRUCTIONS

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Other	Date Medication Needed:
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Physician's Name (Please Print) _____

Physician's Address _____

Phone _____ Fax _____

Dr.'s Office Contact Name _____

Physician's Signature _____ Date _____

Physician's DEA# _____

License # _____ NPI _____

Fax completed form to Medex BioCare (866) 755-6339