

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)	

Subscribers Name	Relationship to Patient
_____	_____
Policy #	Group #
_____	_____
Primary Insurance Phone	

Prescription Card (Fax copy of card – both sides)	

Carrier	Policy #
_____	_____

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses)	
<input type="checkbox"/> 340 Multiple Sclerosis	<input type="checkbox"/> Other ICD 9
Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of diagnosis
Height _____ Weight _____	Allergies:

PRESCRIPTION INFORMATION				
Medication	Dose	Frequency	Quantity	Refills
<input type="checkbox"/> Avonex® (Interferon beta-1a)	30 mcg/QW prefilled syringe or vial			
<input type="checkbox"/> Betaseron® (Interferon beta-1b)	25 mg/QOD			
<input type="checkbox"/> Copaxone® (Glatiramer acetate)	20 mg/QD			
<input type="checkbox"/> Novantrone (Mitoxantrone)	22 mcg/ 44 mcg/ TIW			
<input type="checkbox"/> Rebif® (Interferon beta-1a)	10 ml 12.5 ml 15 ml			

DELIVERY INSTRUCTIONS		
<input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other	Address _____ City/State/Zip _____	Date Medication Needed

Physician's Name (Please Print)	Physician's DEA#
Physician's Address	
Phone	Physician's Signature
Fax	Date
License #	Dr.'s Office Contact Name
UPIN #	Contact Phone #

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