



Multiple Sclerosis (MS) Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND
FAX TO: 1-888-773-7386 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information New Rx Refill

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____
 Date of Birth (mm/dd/yyyy): ____ / ____ / ____

Phone #1: _____ Phone #2: _____
 Allergies: _____ No Known Allergies
 Health Conditions: _____
 Expected Start Date: ____ / ____ / ____

Statement of Medical Necessity

Patient Weight: _____ lbs kg Primary Diagnosis: _____ ICD9 Code: _____
 Number of Relapses in Past Year: _____ History of tried and failed therapy: Avonex Betaseron Copaxone Extavia
 Rebif Other: _____ Reason for discontinuation: _____
 Last MRI date: ____ / ____ / ____ Any MRI Changes? Yes No
 Nurse teaching visit through: MS Active Source™ BETAPLUS™ Shared Solutions™ MSLifeLines®

Drug Delivery Information

If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery Home Delivery for Self Injection/Administration Home Delivery for Home Health Administration
 Other: _____
 Contact: _____
 Phone #: _____
 Address: _____

Insurance Information

Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____ Secondary: _____
 Insured: _____ Insured: _____
 ID #: _____ Group #: _____ ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____ Phone #: _____ Rx Drug Card #: _____
 RxBin #: _____ RxPCN #: _____ Rx Grp #: _____ RxBin #: _____ RxPCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information

NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____ Office Contact: _____
 Address: _____ NPI #: _____ DEA #: _____
 City: _____ ST: _____ Zip: _____ Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING Rx FORM -OR- TAPE Rx HERE

Rx		Date: ____ / ____ / ____
Drug Name/Form/Strength	Directions for Use	
<input type="checkbox"/> AVONEX® <input type="checkbox"/> 30mcg Pre-filled Syringe <input type="checkbox"/> 30mcg Vial		
<input type="checkbox"/> BETASERON® 0.3mg Vial		
<input type="checkbox"/> COPAXONE® 20mg Pre-filled Syringe		
<input type="checkbox"/> EXTAVIA® 0.25mg Kit		
<input type="checkbox"/> REBIF® <input type="checkbox"/> 22 mcg Pre-filled Syringe <input type="checkbox"/> 44 mcg Pre-filled Syringe <input type="checkbox"/> Rebif titration pack		
Other:	Quantity: _____	Refills: _____
Needles Gauge: _____ Inches: ____ Quantity: ____ Refills: ____	Syringes Volume: _____ Inches: ____ Quantity: ____ Refills: ____	
X _____ Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted	X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted	

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.
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