

Send updates to: Fax: _____ Email: _____

Physician Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice Name / Supervising MD:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:
Policyholder Name:	Policyholder DOB:	BIN: PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: <input type="radio"/> Multiple Sclerosis <input type="radio"/> Other:	Has patient been previously treated for this condition? Y N
Prior failed medication (medication and duration of treatment/reason for d/c): <input type="radio"/>	
Patient currently on therapy? <input type="radio"/> Y <input type="radio"/> N Medication(s):	Will patient be stopping above medication before starting new therapy? <input type="radio"/> Y <input type="radio"/> N Discontinuation Date: / /
Is prescriber a Neurologist? If no, please include neurology consult if available <input type="radio"/> Other:	Number of relapses in past year: Last MRI date: / / Any MRI changes? <input type="radio"/> Y <input type="radio"/> N
Is patient pregnant, nursing or planning pregnancy? <input type="radio"/> Y <input type="radio"/> N <input type="radio"/> N/A	<input type="radio"/> Serum Creatine: <input type="radio"/> Creatinine Clearance:

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
<input type="radio"/> AVONEX® <input type="radio"/> PFS <input type="radio"/> Pen <input type="radio"/> Lypholized Pwdr Vial	<input type="radio"/> 30mcg/0.5ml (#4)	<input type="radio"/> Inject 30mcg IM once weekly <input type="radio"/> Other Regimen:	28 Day Supply	
<input type="radio"/> BETASERON®	<input type="radio"/> 0.3mg kit PFS (#14)	<input type="radio"/> Dose Titration: Titration kit=35DS Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD <input type="radio"/> Other Regimen: Weeks 3-4: Inject 0.125mg/0.50ml SQ QOD Weeks 5-6: Inject 0.1875mg/0.75ml SQ QOD Weeks 7+: Inject 0.25mg/1ml SQ QOD <input type="radio"/> Maintenance Dose: Inject 0.25mg/1ml SQ QOD	<input type="radio"/> Titration Dose: 35 Day Supply <input type="radio"/> Maintenance Dose: 28 Day Supply	
<input type="radio"/> COPAXONE® <input type="radio"/> GLATIRAMER ACETATE <input type="radio"/> GLATOPIA®	<input type="radio"/> 20mg/ml PFS (#30) <input type="radio"/> 40mg/ml PFS (#12)	<input type="radio"/> Inject 20mg SQ QD <input type="radio"/> Inject 40mg SQ 3x a week (at least 48 hours apart)	<input type="radio"/> 30 Day Supply <input type="radio"/> 28 Day Supply	
<input type="radio"/> EXTAVIA®	<input type="radio"/> 0.3mg kit PFS (#15)	<input type="radio"/> Dose Titration: Titration kit=49DS, 20 Vials Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD <input type="radio"/> Other Regimen: Weeks 3-4: Inject 0.125mg/0.50ml SQ QOD Weeks 5-6: Inject 0.1875mg/0.75ml SQ QOD Weeks 7+: Inject 0.25mg/1ml SQ QOD <input type="radio"/> Maintenance Dose: 0.25mg/1ml SQ QOD	<input type="radio"/> Titration Dose: 49 Day Supply <input type="radio"/> Maintenance Dose: 30 Day Supply	
<input type="radio"/> GILENYA®	<input type="radio"/> 0.5mg capsule (#30)	<input type="radio"/> Take 0.5mg by mouth QD	<input type="radio"/> 30 Day Supply <input type="radio"/> 60 Day Supply <input type="radio"/> 90 Day Supply	
<input type="radio"/> REBIF® <input type="radio"/> REBIF® REBIDOSE® Autoinjector	<input type="radio"/> Titration Pack (8.8mcg/22mcg) (#12) <input type="radio"/> 22mcg/0.5ml PFS (#12) <input type="radio"/> 44mcg/0.5ml PFS (#12)	<input type="radio"/> Dose Titration: <input type="radio"/> Inject 8.8mcg SQ 3x a week at weeks 1-2, 22mcg SQ 3x a week at weeks 3-4, and 44mcg SQ 3x a week at weeks 5+ (48 hours apart) <input type="radio"/> Inject 4.4mcg SQ 3x a week at weeks 1-2, 11mcg SQ 3x a week at weeks 3-4, and 22mcg SQ 3x a week at weeks 5+ (48 hours apart) <input type="radio"/> Maintenance: Inject 22mcg (0.5ml) SQ 3x a week (48 hours apart) <input type="radio"/> Maintenance: Inject 44mcg (0.5ml) SQ 3x a week (48 hours apart) <input type="radio"/> Other Regimen:	<input type="radio"/> Titration Dose: 28 Day Supply (12 pens or syringes) <input type="radio"/> Maintenance Dose: 28 Day Supply	
<input type="radio"/> Other Specialty:				

Injection Training

<input type="radio"/> Patient received injection training	<input type="radio"/> Prescriber's office to provide injection training	<input type="radio"/> Meijer to coordinate injection training
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By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____	Date: _____	Physician Signature: _____	Date: _____
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