

Ship Meds to: Patient's Home Prescriber's Office

Prescriber 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 (G35) <input type="radio"/> Other:	Has patient been previously treated for this condition? <input type="radio"/> Y <input type="radio"/> N
Type: <input type="radio"/> Clinically isolated syndrome <input type="radio"/> Relapsing-Remitting <input type="radio"/> Primary Progressive <input type="radio"/> Secondary Progressive	
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"/> Y <input type="radio"/> N <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 Creatinine: <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: Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD 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"/> Other Regimen:		
<input type="radio"/> COPAXONE® <input type="radio"/> GLATIRAMER ACETATE <input type="radio"/> GLATOPA®	<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"/> DALFAMPRIDINE (generic Ampyra®)	<input type="radio"/> 10mg tablets (#60)	<input type="radio"/> Take 1 tablet by mouth every 12 hours	<input type="radio"/> 30 Day Supply	
<input type="radio"/> DIMETHYL FUMARATE (generic Tecfidera®)	<input type="radio"/> 120mg capsules (#14) <input type="radio"/> 240mg capsules (#60)	<input type="radio"/> Starter Dose: Take 120mg by mouth twice daily for 7 days <input type="radio"/> Maintenance Dose: Take 240mg by mouth twice daily	<input type="radio"/> 7 Day Supply <input type="radio"/> 30 Day Supply	No Refills
<input type="radio"/> EXTAVIA®	<input type="radio"/> 0.3mg kit PFS (#15)	<input type="radio"/> Dose Titration: Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD 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"/> Other Regimen:		
<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"/> 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.

Prescriber Signature: _____	Date: _____	Prescriber Signature: _____	Date: _____
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.