

Prescriber Information				
Prescriber Name:	MD DO NP PA			NPI:
Office Contact:	Practice Name / Collaborating MD:			
Address:	City:	State:	Zip:	
Phone:	Fax:			

Patient Information • PLEASE SEND COPY OF INSURANCE CARD				
Patients Name:	Last 4 Digits of SS#:	DOB: / /	Sex: M F	Weight: Height: Diabetic? Y N
Office Contact:	Practice Name / Collaborating MD:			
Address:	City:	State:	Zip:	
Home Phone:	Work/Cell:	HIPPA Contact:	Emergency #:	
Interpreter Needed? Y N	Allergies: Y N If Yes, list allergies:			

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

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:	Multiple Sclerosis (G35) Other:	Has patient been previously treated for this condition? Y N		
Type:	Clinically isolated syndrome Relapsing-Remitting Primary Progressive Secondary Progressive			
Prior failed medication (medication and duration of treatment/reason for d/c):				
Patient currently on therapy? Y N	Medication(s):	Will patient be stopping above medication before starting new therapy? Y N		
Discontinuation Date: / /	Is prescriber a Neurologist? If no, include neurology consult if available Y N Other:			
Number of relapses in past year:	Last MRI Date: / /	Any changes? Y N	Is patient pregnant, nursing or planning pregnancy? Y N N/A	
Serum Creatinine:	Creatinine Clearance:			

Prescription Information				
Medication	Dose/Strength	Sig	Quantity	Refills
AVONEX® PFS Pen Lypholized Pwdr Vial	30mcg/0.5ml (#4)	Inject 30mcg IM once weekly Other Regimen:	28 Day Supply	
BAFIERTAM™ Monomethyl fumarate	95mg capsules	Starter Dose: Take 1 capsule (95mg) by mouth twice daily for 7 days, then take 2 capsules (190mg) by mouth twice daily thereafter	1 bottle (120 capsules)	No Refills
		Maintenance Dose: Take 2 capsules (190mg) by mouth twice daily	30 Day Supply	
BETASERON®	0.3mg kit PFS (#14)	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 Maintenance Dose: Inject 0.25mg/1ml SQ QOD Other Regimen:	28 Day Supply	
COPAXONE® GLATIRAMER ACETATE® GLATOPA®	20mg/ml PFS (#30)	Inject 20mg SQ QD	30 Day Supply	
	40mg/ml PFS (#12)	Inject 40mg SQ 3x a week (at least 48 hours apart)	28 Day Supply	
DALFAMPRIDINE (generic Ampyra®)	10mg tablets (#60)	Take 1 tablet by mouth every 12 hours	30 Day Supply	
Other Specialty:				

Injection Training		
Patient received injection training	Prescriber's office to provide injection training	Meijer to coordinate injection training

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

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