

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"/> 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"/> KESIMPTA®	<input type="radio"/> 20mg/0.4ml pen	<input type="radio"/> Starter Dose: Inject 1 pen (20mg) SQ at weeks 0, 1 and 2. Begin maintenance dose at week 4. <input type="radio"/> Maintenance Dose: Inject 1 pen (20mg) SQ monthly	28 day supply	No Refills
<input type="radio"/> MAYZENT®	New Start Patients: Please fax Mayzent® Prescription Start Form to Mayzent's HUB (Alongside MS™) at 1-877-750-9068. <input type="radio"/> 0.25mg tablets <input type="radio"/> 1mg tablets			
		Established Patients (have already completed dose titration): <input type="radio"/> Take 1mg by mouth daily <input type="radio"/> Take 2mg by mouth daily	30 day supply	
<input type="radio"/> PLEGRIDY™	Starter Pack: <input type="radio"/> Prefilled syringe (1x63mcg/0.5ml, 1x94mcg/0.5ml) <input type="radio"/> Autoinjector pen (1x63mcg/0.5ml, 1x94mcg/0.5ml)	Dose Titration: <input type="radio"/> Inject 63mcg SQ on day 1 and 94mcg SQ on day 14	Titration Dose: 28 day supply	No Refills
	<input type="radio"/> 125mcg/0.5ml PFS <input type="radio"/> 125mcg/0.5ml autoinjector	<input type="radio"/> Maintenance Dose: Inject 125mcg SQ every 14 days, starting on day 29	Maintenance Dose: 28 day supply	
<input type="radio"/> 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

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