

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"/> 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)	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"/> Titration Starter Pack (30 day supply) <input type="radio"/> 120mg capsules <input type="radio"/> 240mg capsules	<input type="radio"/> Titration Starter Pack: Take 120mg by mouth twice daily for 7 days, then 240mg twice daily thereafter <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	1 pack (30 day supply) 7 day supply 30 day supply	No Refills No Refills No Refills
<input type="radio"/> VUMERITY®	<input type="radio"/> 231mg capsules	<input type="radio"/> Starter Dose: Take 231mg by mouth twice daily for 7 days, then take 462mg (two 231mg capsules) by mouth twice daily thereafter	30 day supply	No Refills
		<input type="radio"/> Maintenance Dose: Take 462mg (two 231mg capsules) by mouth twice daily	30 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.