Multiple Sclerosis
Prescription &
Pharmacy Intake Form

evers SPECIALTY PHARMACY

Phone: 1-718-762-7400
Fax: 1-718-762-7404
Toll Free: 1-888-93-EVERS

Provider Representative | **Phone** | **Date Needed** | **Ship to** ☐Specialty Care Center ☐Patient's Home ☐Prescriber's Office ☐Other_____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ ☐ Male ☐ Female
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____
Insurance Provider (**Please include copy of front and back of card**): _____
ID #: _____ Policy/Group #: _____ Phone #: _____
Name of Insured: _____ Employer: _____
Relationship to Patient: ☐ Self ☐ Other: _____ ☐ Patient is Eligible for Medicare
Prescription Card: ☐ Yes ☐ No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Restart
☐ Patient is Currently on Therapy
(Start Date: _____)

Primary ICD-9 Code: _____
Diagnosis: ☐ RRMS ☐ SPMS ☐ PPMS ☐ PRMS
Date of Diagnosis: _____

Current Weight: _____ Date: _____

Current Therapy: ☐ Avonex® ☐ Betaseron® ☐ Copaxone® ☐ Extavia® ☐ Gilenya® ☐ Novantrone® ☐ Rebif® ☐ Tysabri®

Other Therapies Tried & Failed (Please List):
_____
_____

Other Health Conditions: _____
_____

Allergies: _____
_____

Concomitant Medications: _____
_____

Medication	Dose/Directions/Freq	Qty	Refills
Avonex® (interferon beta-1a) ☐ 30 mcg ☐ Prefilled Syringes ☐ Lyo Vial			
☐ **Betaseron® (interferon beta-1b)**			
Copaxone® (glatiramar acetate) ☐ 20 mg Prefilled Syringes			
☐ **Extavia® (interferon beta-1b)**			
Gilenya® (fingolimod) ☐ 0.5 mg capsules			
Novantrone® (mitoxantrone) ☐ 10 mg/5 mL ☐ 20 mg/10 mL ☐ Other			
Rebif® (interferon beta-1a) ☐ Titration Kit ☐ 22 mcg Prefilled Syringes ☐ 44 mcg Prefilled Syringes			
Tysabri® - Contact Touch (Biogen Idec) at 1-800-456-2255 or at 1-800-840-1278 (fax)			
☐ Other: _____			
Symptom Management Medications			
Ampyra® (dalfampridine) ☐ 10 mg Extended Release Tablet			
☐ **Lioresal® IT (baclofen)**			
☐ Other: _____			

PRESCRIBER INFORMATION

Prescriber's Name: _____ Practice/Facility Name: _____
Address: _____ Office Contact: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Fax: _____ Best Time to Call: _____
State License #: _____ DEA #: _____ NPI#: _____ Medicaid UPIN #: _____
In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**," or your state specific required language to prohibit substitution: _____
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: _____ Date: _____