

Multiple Sclerosis

Prescription & Pharmacy Intake Form



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

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.
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Drug names are the property of their respective owners.