CoxHealth at Home

Multiple Sclerosis Self-Injectable Agents (A-D)

PHONE: 1-855-419-4663
FAX: 1-417-269-0692

Information	**Prescriber + Shipping Information**
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: ❑ Female ❑ Male SSN: _____	NPI: _____
Language: _____ Wt: ____ ❑kg ❑lbs Ht: _____ ❑cm ❑in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ _____ Alternate: _____	Phone: _____ ___ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ ____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: ❑ First Fill ❑ Always Never
Please fax a copy of front and back of the insurance card(s).	

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ G35 (Multiple Sclerosis) ❑ _____ _____ Diagnosis Date: _____

Type: ❑ Clinically isolated syndrome ❑ Relapsing-remitting ❑ Secondary-progressive ❑ Primary-progressive ❑ Progressive-relapsing

Hepatic Impairment present: ❑ Yes ❑ No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____

Pre-existing hepatic conditions: ❑ HBV ❑ HCV ❑ _____ TB Test: ❑ Positive ❑ Negative Test date: _____

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____ ___	_____	_____ _	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____

Concomitant Medications: _____

Allergies: ❑ NKDA ❑ Other: _____

Prescription		**Quantity**		**Refill**
❑ **Avonex®** (interferon beta-1a)	❑ Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	4 x 30 mcg	❑ Pens ❑ PFS ❑ Vials	0
	❑ Inject 30 mcg intramuscularly once weekly	4 x 30 mcg	❑ Pens ❑ PFS ❑ Vials	_____
❑ **Betaseron®** (interferon beta-1b)	❑ Week 1-2: Inject 0.0625 mg (0.25 mL) SQ every other day Week 3-4: Inject 0.125 mg (0.5 mL) SQ every other day Week 5-6: Inject 0.1875 mg (0.75 mL) SQ every other day Week 7-8: Inject 0.25 mg (1 mL) SQ every other day	14 x 0.3 mg	Vials	0
	❑ Inject 0.25 mg (1 mL) SQ every other day	14 x 0.3 mg	Vials	_____
❑ **Copaxone®** (glatiramer acetate)	❑ Inject 20 mg SQ daily	30 x 20 mg	PFS	_____
	❑ Inject 40 mg SQ three times per week at least 48 hours apart	12 x 40 mg	PFS	_____
❑ **Glatiramer Acetate**	❑ Inject 20 mg SQ daily	30 x 20 mg	PFS	_____
	❑ Inject 40 mg SQ three times per week at least 48 hours apart	12 x 40 mg	PFS	_____
❑ WhisperJECT™	Autoinjector for use with Glatiramer Acetate (manufacturer limit of one per year)	1 unit	Delivery Device	0
❑ **Glatopa™** (glatiramer acetate)	Inject 20 mg SQ daily	30 x 20 mg	PFS	_____

For additional MS Injectables, see other referral form. MS Injectable (E-Z)

Injection Training Provided by: ❑ Prescriber's Office ❑ CoxHealth at Home ❑ Other: _____

For patients requiring immune globulin therapy, please fill out the respective form (IVIG or Subq IG)

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home

CoxHealth