

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Male Female
 Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

Diagnosis and ICD10: _____ Weight: _____ kg lbs Height: _____ cm in %BSA: _____
 Has the patient been treated for this condition previously? Yes No Allergies: _____ NKDA
 Is the patient currently on therapy? Yes No Injection Training/Home Health RN visit is necessary. Yes No
 What other medications has the patient tried and failed? _____ Site of Care: Home MD Office Other: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
<input type="checkbox"/> AJOVY™	<input type="checkbox"/> 225mg <input type="checkbox"/> 675mg	<input type="checkbox"/> Inject 225mg SUBQ once monthly <input type="checkbox"/> Inject 675mg SUBQ quarterly <i>(3 - 225mg injections consecutively every 3 mos.)</i>	1 month supply 3 month supply	
<input type="checkbox"/> Avonex®	<input type="checkbox"/> 30mcg PFS <input type="checkbox"/> 30mcg vial <input type="checkbox"/> 30mcg Pen	<input type="checkbox"/> Initial: Avostartgrip (Week 1: 7.5mcg, Week 2: 15mcg, Week 3: 22.5mcg, Week 4: 30mcg) <input type="checkbox"/> Maintenance: Inject 30mcg IM once weekly <input type="checkbox"/> Other: _____	1 month supply	
<input type="checkbox"/> AIMOVIQ®	<input type="checkbox"/> 70mg <input type="checkbox"/> PFS <input type="checkbox"/> 140mg <input type="checkbox"/> Pen	<input type="checkbox"/> Inject 70mg SUBQ once monthly <input type="checkbox"/> Inject 140mg SUBQ once monthly <i>(2 - 70mg injections consecutively)</i>	1 month supply	
<input type="checkbox"/> Betaseron®	<input type="checkbox"/> 0.3 mg PFS	<input type="checkbox"/> Initial: Week 1&2: 0.25ml (0.0625mg), Week 3&4: 0.5ml (0.125mg) Week 5&6: 0.75ml (0.1875mg), Week 7+ 1ml (0.25mg) SUBQ every other day <input type="checkbox"/> Maintenance: Inject 1ml (0.25mg) SUBQ every other day	1 month supply	
<input type="checkbox"/> Copaxone®	<input type="checkbox"/> 20mg PFS <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 20mg SUBQ every day <input type="checkbox"/> Inject 40mg SUBQ 3 times weekly	1 month supply	
<input type="checkbox"/> Extavia®	<input type="checkbox"/> 0.3mg Kit	<input type="checkbox"/> Inject 0.25mg SUBQ every other day	1 month supply	
<input type="checkbox"/> Gilenya™	<input type="checkbox"/> 0.5mg cap	<input type="checkbox"/> Take 1 capsule by mouth once daily	1 month supply	
<input type="checkbox"/> Glatopa™	<input type="checkbox"/> 20mg PFS <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 20mg SUBQ every day <input type="checkbox"/> Inject 40mg SUBQ 3 times weekly	1 month supply	
<input type="checkbox"/> Rebif® <input type="checkbox"/> Rebidose®	<input type="checkbox"/> Titration Pack <input type="checkbox"/> 22mcg PFS <input type="checkbox"/> 44mcg PFS	<input type="checkbox"/> Initial: Week 1&2: 0.2ml (8.8mcg), week 3&4: 0.5ml (22mcg) SUBQ three times weekly <input type="checkbox"/> Maintenance: Inject 0.5ml (22mcg) SUBQ three times weekly <input type="checkbox"/> Maintenance: Inject 0.5ml (44mcg) SUBQ three times weekly <input type="checkbox"/> Other: _____	1 month supply	
<input type="checkbox"/> Epipen® <input type="checkbox"/> Epipen® Jr	<input type="checkbox"/> 2 pack	<input type="checkbox"/> 1 pen into thigh in case of anaphylaxis	1 box of 2	
<input type="checkbox"/> Other:				

By signing this form and using our services, you are authorizing InfuCare Rx to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____