InfuCare Rx®

Multiple Sclerosis Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
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:

DIAGNOSIS/CLINICAL INFORMATION

Multiple Sclerosis:

☐ G35 Multiple Sclerosis
☐ G35 Relapsing/Remitting
☐ G35 Primary Progressive
☐ G35 Secondary Progressive
☐ Other: _____

Number of Relapses the past year: _____
Date of Diagnosis: _____
Date of last MRI: _____ MRI Changes: ☐ Yes ☐ No

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Prior Treatment: ☐ Avonex® ☐ Copaxone® ☐ Rebif® ☐ Betaseron® ☐ Extavia® ☐ Other: _____

Treatment Response: _____ Treatment Dates: _____
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Lab Data: _____
Concomitant Medications: _____
Comorbidities: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Avonex® (Biogen Idec) ☐ Betaseron® (Bayer) ☐ Copaxone® (Teva) ☐ Extavia® (Novartis) ☐ Gilenya® (Novartis) ☐ Glatopa® (Sandoz) ☐ Rebif® (EMD Serono)	☐ 30mcg Syringe ☐ 30mcg Pen ☐ 30mcg Vial ☐ 0.3mg Vial & Diluent ☐ 20mg Syringe ☐ 40mg Syringe ☐ 0.3mg Vial & Diluent ☐ 0.5mg Capsule ☐ 20mg per 1mL Syringe ☐ Titration Pack ☐ Rebidose® AutoInjector Titration ☐ 22mcg Syringe ☐ Rebidose® AutoInjector 22mcg ☐ 44mcg Syringe ☐ Rebidose® AutoInjector 44mcg			

ADDITIONAL COMMENTS:

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X _____ X _____

PRODUCT SUBSTITUTION PERMITTED (Date) **DISPENSE AS WRITTEN** (Date)

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