

Injection Training: MD Office
 Pharmacy to Arrange

Ship To : Patient Home MD Office

MAIN POINT OF CONTACT

Name: _____
Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)

Name: _____ Phone: _____ Phone 2: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
DOB: _____ SSN: _____ Sex: Male Female Height: _____ Weight: _____ lbs.
Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance: _____ Secondary Insurance: _____
ID#: _____ RxBin: _____ ID#: _____ RxBin: _____
RxGroup: _____ Pcn: _____ RxGroup: _____ Pcn: _____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis: _____ ICD10 Code: _____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Avonex Powder Vial	30 mcg			
<input type="checkbox"/> Avonex Prefilled Syringe	30 mcg			
<input type="checkbox"/> Betaseron	0.3 mg			
<input type="checkbox"/> Copaxone	40 mg Pre-filled Syringe			
<input type="checkbox"/> Extavia	0.3 mg			
<input type="checkbox"/> Gilenya	0.5 mg			
<input type="checkbox"/> Rebif Titration Pack Box (12 syringes)	<input type="checkbox"/> 8 mcg <input type="checkbox"/> 22 mcg <input type="checkbox"/> 44 mcg			
<input type="checkbox"/> Rebif Box (12 syringes)	<input type="checkbox"/> 22 mcg/0.5ml <input type="checkbox"/> 44 mcg/0.5ml			
<input type="checkbox"/> Tysabri	<input type="checkbox"/> 300 mg/15ml (20mg/ml)			

Rx Allergies: _____

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name: _____ NPI#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

***Prescriber Signature:** _____ **Date:** _____

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