

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City, State	Zip	Date of Birth / /
Shipping Address (if different from home address)	Ship to MD	Home Phone Number ()	Work Phone Number ()

INSURANCE INFORMATION

(fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Diagnosis: Multiple Sclerosis Relapsing - Remitting Primary - Progressive Progressive - Relapsing Other: _____

Date of Diagnosis: _____ Number of Relapses in past year: _____ See Attached

Date of Last MRI: _____ Changes in MRI No Yes _____ See Attached

Current Medications: _____ See Attached

Allergies: _____ NKDA

Previous Treatment with
Avonex Betaseron Copaxone Extavia Rebif Other: _____ Dates of Therapy: _____ See Attached

If previously treated; reason for discontinuation or retreatment: _____ See Attached

PRESCRIPTION INFORMATION

<p>Avonex 30mcg/0.5ml PFS <u>OR</u> Avonex 30mcg/1ml vial Inject 30mcg IM once a week Alternate Directions: _____ Qty _____ Refill x _____ Enroll in MS ActiveSource®</p>	<p>Betaseron 0.3mg vial Mix 1.2ml of provided diluent and inject 0.25mg (1ml) SQ other day Alternate Directions: _____ Qty _____ Refill x _____ Enroll in BETAPLUS®</p>
<p>Copaxone 20mg/1ml PFS Inject 20mg (1ml) SQ every day Alternate Directions: _____ Qty _____ Refill x _____ Enroll in Shared Solutions®</p>	<p>Extavia 0.3mg vial Mix 1.2ml of provided diluent and inject 0.25mg (1ml) SQ every other day Alternate Directions: _____ Qty _____ Refill x _____ Enroll in MS Inspirations®</p>
<p>Choose Medication:</p> <p>Rebif Titration Pack Choose Sig: Inject 8.8mcg (0.2ml) SQ TIW for weeks 1-2 and 22mcg (0.5ml) SQ TIW for weeks 3-4</p> <p>Rebif 22mcg/0.5ml Inject 22mcg SQ TIW</p> <p>Rebif 44mcg/0.5ml Inject 44mcg (0.5ml) SQ TIW</p> <p>Other: _____</p> <p>Rebifect II Autoinjector (to be provided by MS Lifelines) Enroll in MS Lifelines®/Needs Nurse Training Qty _____ Refill x _____</p>	
<p>Other Directions: _____ Qty _____ Refill x _____</p>	

PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number ()
Address	City, State	Zip	Fax Number ()
Today's Date	Date Needed By	DEA	On File NPI On File

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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