CoxHealth at Home

Multiple Sclerosis Self-Injectable Agents (A-D)

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

Information

Patient name: ________________________ DOB: ____________
Sex: ❑ Female ❑ Male SSN: ____________________________
Language: ____________ Wt: _____ ❑kg ❑lbs Ht: _____ ❑cm ❑in
Address: ____
Apt/Suite: _____ City: ________________ State: _____ Zip: ______
Phone: ____________ ________ Alternate: __________________
Caregiver name: ____________________ Relation: ____________
Local pharmacy: __________________ Phone: _____________
Insurance plan: _________________ Plan ID: ______________
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: ____________________________________
NPI: ____
Address: ____
Apt/Suite: ______ City: ____________ State: _______ Zip: ______
Contact: ____
Phone: ________________ ___ Alternate: __________________
Fax: ____
Email: ____
If shipping to prescriber: ❑ First Fill ❑ Always Never

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

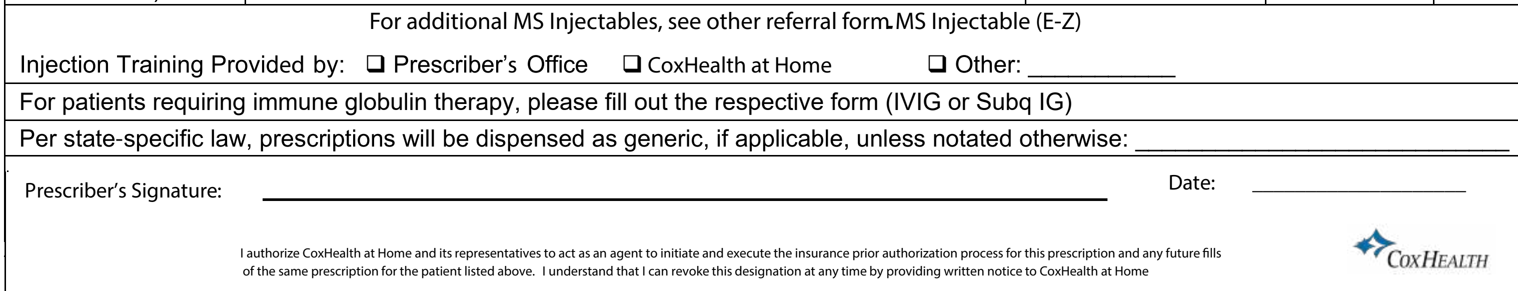
Prescription		Quantity		Refill
❑ **Avonex®** (interferon beta-1a)	❑ Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly 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) subq every other day Week 3-4: Inject 0.125 mg (0.5 mL) subq every other day Week 5-6: Inject 0.1875 mg (0.75 mL) subq every other day Week 7-8: Inject 0.25 mg (1 mL) subq every other day	14 x 0.3 mg	Vials	0
	❑ Inject 0.25 mg (1 mL) subq every other day	14 x 0.3 mg	Vials	_____
❑ **Copaxone®** (glatiramer acetate)	❑ Inject 20 mg subq daily	30 x 20 mg	PFS	_____
	❑ Inject 40 mg subq three times per week at least 48 hours apart	12 x 40 mg	PFS	_____
❑ **Glatiramer Acetate**	❑ Inject 20 mg subq daily	30 x 20 mg	PFS	_____
	❑ Inject 40 mg subq 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 subq 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

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