CoxHealth at Home

Multiple Sclerosis
Self-Injectable Agents (drugs E-Z)

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
❑ Extavia® (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-onward: Inject 0.25 mg (1 mL) subq every other day.	15 x 0.3 mg	Vials	0 0
	❑ Inject 0.25 mg (1 mL) subq every other day	15 x 0.3 mg	Vials	_____
❑ Rebif® (interferon beta-1a)	❑ Week 1-2: Inject 4.4 mcg (0.1 mL) subq three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subq three times per week.	6 x 8.8 mcg 6 x 22 mcg	❑ PFS ❑ Autoinjector	0
	Week 5 and thereafter: Inject 22 mcg subq three times per week	12 x 22 mcg	❑ Autoinjectors ❑ PFS	_____
	❑ Week 1-2: Inject 8.8 mcg (0.2 mL) subq three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subq three times per week.	6 x 8.8 mcg 6 x 22 mcg	❑ Autoinjectors ❑ PFS	0
	Week 5 and thereafter: Inject 44 mcg subq three times per week	12 x 44 mcg	❑ Autoinjectors ❑ PFS	_____
❑ Plegridy® (peginterferon beta-1a)	❑ Inject 63 mcg subq on day 1; then inject 94 mcg on day 15	1 x 63 mcg 1 x 94 mcg	❑ Pens ❑ PFS	0
	❑ Inject 125 mcg subq day 29 and every two weeks thereafter	2 x 125 mcg	❑ Pens ❑ PFS	_____

For additional MS Injectables, see other referral form MS Injectable (A-D)

Injection Training Provided by: ❑ Prescriber's Office ❑ CoxHealth at Home ❑ Training not needed ❑ Other: ____________________

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

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

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure underapplicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying thisinformation. If you received this communication in error, please notify the sender immediately by calling 1 855-419-4663 to obtain instructions as to the proper destruction of the transmitted material. Thank you.

Last Reviewed: 11-29-19