

Patient Information				Prescriber Information	
Patient Name:		DOB:		Prescriber's Name:	
Address:				NPI#:	
City:	State:	Zip:	DEA#:		License#:
Phone:	Alternate Phone:		SSN:	Address:	
Height:	Weight:	Allergies:		Phone:	Fax:
Emergency Contact:		Phone:		Contact Person:	
Is the patient pregnant, planning a pregnancy or nursing:			Yes	No	Does the patient need interpreter services:
					Yes No

Documentation (Required)		
Insurance Card (front and back)	Current Medications	History/Progress Notes

Prior Therapies					
Expected date of injection _____/_____/_____		Last injection date _____/_____/_____			
Date of pregnancy test _____/_____/_____		Results + -			
	LEVF	Platelets	ANC	Bilirubin	
Result:					
Date:					

Client Considerations	
Diagnosis (ICD 10):	G35 Multiple Sclerosis Other (please specify): _____

Medication	Strength/Directions for Use		Refills
AVONEX® (interferon beta 1-a)	30mcg pre-filled syringe	Inject 30mcg SC once weekly _____	
COPAXONE® (glatiramer acetate)	20mg pre-filled syringe Start: 400mg SC x 1 on weeks 0, 2, 4 40mg pre-filled syringe	Inject 20mg SC once daily Inject 40mg SC TIW _____	
GILENYA® (fingolimod)	0.5mg capsule	1 capsule by mouth daily _____	
REBIF® (interferon beta-1a)	22mcg prefilled syringe 44mcg prefilled syringe	Inject 22mcg SC three times weekly Inject 44mcg SC three times weekly _____	

4 week supply REFILL _____ times

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature

Date