

MULTIPLE SCLEROSIS

TELEPHONE 1-800-237-2767 FAX 1-800-323-2445

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)		Social Security #	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance		Secondary/Pharmacy Insurance	
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)	
Group/Policy #		Group/Policy #	
Insurance Telephone # (+Area Code)		Insurance Telephone # (+Area Code)	
Employer		Medicaid #	

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name	
Hospital/Clinic		Office Contact	
Street Address			
City		State	ZIP
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address
Prescriber's License #		DEA #	NPI #
UPIN#		Medicaid License #	

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:
ICD-9 CM: 340 Multiple Sclerosis Relapsing/Remitting Progressive
 Other _____ Date of Diagnosis: / /

INJECTION TRAINING:
Injection training will be/has been conducted by the physician's office?
 Yes No Date: / /
First dose of medication will be/has been administered at physician's office?
 Yes No Date: / /
Skilled home nursing visit to provide injection training?
 Yes No Date: / /

Rx

Avonex® SIG: 30 mcg IM QW with ancillary supplies
 28 day supply 84 day supply Other _____
 Enroll in MS ActiveSource®

Betaseron® SIG: 0.25 mg SQ QOD with ancillary supplies
 DOSE TITRATION:
wks 1 - 2 / 0.0625 mg / 0.25 mL SQ QOD wks 3 - 4 / 0.1250 mg / 0.50 mL SQ QOD
wks 5 - 6 / 0.1875 mg / 0.75 mL SQ QOD wks 7 - + / 0.2500 mg / 1.00 mL SQ QOD
 30 day supply 90 day supply
 Enroll in MS PathwaysSM Beta RN Training

Copaxone®

Autoject® 2 for glass syringe – Refill: PRN
SIG: 20 mg SQ QD with ancillary supplies
 30 day supply 90 day supply
 Enroll in Shared Solution® (Provides Autoject® 2 Delivery)

Rebif®

Rebject® – PRN – use as directed
SIG: 8.8 mcg SQ TIW-weeks 1-2, 22mcg SQ TIW-weeks 3-4, 44 mcg SQ TIW-weeks 5+
 44 mcg SQ TIW Other _____
 Starter Pack (22 mcg) 28 day Maintenance (44 mcg) 28 day
 28 day 84 day supply Other _____
 Enroll in MS LifelinesSM (Provides Rebject® delivery)

Tysabri® – (Please note, this medication requires a special enrollment form. Please contact TOUCH Prescribing Program 1-800-456-2255.)

Coordination for home administration needed

Other _____

Other Prescriber's Notes:

Refill: <input type="checkbox"/> 12 months <input type="checkbox"/> Refill _____ times	
<input type="checkbox"/> Dispense As Written	<input type="checkbox"/> Substitution Allowed

Prescriber's Signature _____ **Date** _____

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!