

**New/Changed Dose****Multiple Sclerosis (Q-Z) Rebif®, Rebif® Rebidoze® Autoinjector,  
Tecfidera®, Vumerity®, Zeposia®****Prescriber Information**

Prescriber Name \_\_\_\_\_ MD DO NP PA NPI \_\_\_\_\_  
 Office Contact \_\_\_\_\_ Practice Name / Collaborating MD \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Patient Information • PLEASE SEND COPY OF INSURANCE CARD**

Patient's Name \_\_\_\_\_ Last 4 Digits of SS# \_\_\_\_\_ DOB / /  
 Sex M F Weight \_\_\_\_\_ Height \_\_\_\_\_ Diabetic? Y N  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work/Cell \_\_\_\_\_ HIPAA Contact \_\_\_\_\_  
 Emergency # \_\_\_\_\_  
 Interpreter Needed? Y N | Allergies Y N If Yes, list allergies \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Policy ID \_\_\_\_\_ Group# \_\_\_\_\_  
 BIN \_\_\_\_\_ PCN \_\_\_\_\_  
 Policyholder Name \_\_\_\_\_ Policyholder DOB / /

**Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE  
CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES,  
AND LAB VALUES**

**ICD-10/Diagnosis Code** Multiple Sclerosis (G35) Other \_\_\_\_\_

Has patient been previously treated for this condition? Y N

**Type** \_\_\_\_\_ Clinically isolated syndrome Relapsing-Remitting Primary Progressive  
Secondary Progressive

Prior failed medication (medication and duration of treatment/reason for d/c) \_\_\_\_\_

Patient currently on therapy? Y N Medication(s) \_\_\_\_\_

Will patient be stopping above medication before starting new therapy? Y N

Discontinuation Date / / Is prescriber a Neurologist? If no, include neurology consult if available Y N  
Other \_\_\_\_\_

Number of relapses in past year \_\_\_\_\_ Last MRI Date / / Any changes? Y N

Is patient pregnant, nursing or planning pregnancy? Y N N/A

Serum Creatinine \_\_\_\_\_ Creatinine Clearance \_\_\_\_\_

**Prescription Information**

Medication	Dose/Strength	Sig	Quantity	Refills
<b>REBIF®</b> <b>REBIF®</b> <b>REBIDOSE®</b> Autoinjector	Titration Pack (8.8 mcg/22 mcg) (#12) 22 mcg/0.5 ml PFS (#12) 44 mcg/0.5 ml PFS (#12)	Dose Titration: Inject 8.8 mcg SQ 3x a week at weeks 1-2, 22 mcg SQ 3x a week at weeks 3-4, and 44 mcg SQ 3x a week at weeks 5+ (48 hours apart)  Inject 4.4 mcg SQ 3x a week at weeks 1-2, 11 mcg SQ 3x a week at weeks 3-4, and 22 mcg SQ 3x a week at weeks 5+ (48 hours apart)  Maintenance Dose: Inject 22 mcg (0.5 ml) SQ 3x a week (48 hours apart)  Maintenance Dose: Inject 44 mcg (0.5 ml) SQ 3x a week (48 hours apart)  Other Regimen _____	Titration Dose: 28 Day Supply (12 pens or syringes)  Maintenance Dose: 28 Day Supply	
<b>TECFIDERA®</b>	Titration Starter Pack (30 day supply)	Titration Starter Pack: Take 120 mg by mouth twice daily for 7 days, then 240 mg twice daily thereafter	1 pack (30 Day Supply)	No Refills
	120 mg capsules	Starter Dose: Take 120 mg by mouth twice daily for 7 days	7 Day Supply	No Refills
	240 mg capsules	Maintenance Dose: Take 240 mg by mouth twice daily	30 Day Supply	
<b>VUMERITY®</b>	231 mg capsules	Starter Dose: Take 231 mg by mouth twice daily for 7 days, then take 462 mg (two 231 mg capsules) by mouth twice daily thereafter	30 Day Supply	No Refills
		Maintenance Dose: Take 462 mg (two 231 mg capsules) by mouth twice daily	30 Day Supply	
<b>ZEPOSIA®</b>	Starter Pack (7 day supply) Starter Kit (28 day supply)	Starter Dose: Take 0.23 mg by mouth daily on days 1-4, then 0.46 mg daily on days 5-7, then 0.92 mg daily thereafter	1 package	No Refills
	0.92 mg capsules	Maintenance Dose: Take 1 capsule by mouth daily	30 Day Supply	

**Injection Training**

Patient received injection training      Prescriber's office to provide injection training  
Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature \_\_\_\_\_  
Date \_\_\_\_\_

*Substitution Permitted*

Prescriber Signature \_\_\_\_\_  
Date \_\_\_\_\_

*Dispense as Written*

If brand is required, please write  
"DAW" in the box to the right.