

PATIENT STATUS		PACKAGING		DELIVERY	
New Patient	Current Patient	Josef Compliance Packaging Vials (Child Proof Yes No)		Patient's home	Pharmacy pickup
New RX	Refill			MD's office	1 st dose at MD's office and remaining refills at patient's home
Primary Caregiver:				Date Needed:	

PATIENT INFO					PRESCRIBER INFO		
Last Name, First Name			Primary Language		Today's Date		
Best Phone Number ()		Alternate Phone Number ()			Physician Name		NPI #
Home Address		City, State	Zip		State License #		DEA #:
Shipping Address (if different from home address)					Address		City, State Zip
Social Security Number			Date of Birth		Phone Number ()		Fax Number ()
Height	Weight	BMI	Gender M F	Pregnant Yes No	Key Office Contact Name		Email

CLINICAL INFORMATION | PLEASE FAX LABS, CURRENT MEDICATIONS/OTC PROFILE AND HISTORY

ICD-9 Code: CM 340 Secondary ICD-9 Code: _____ Date of first demyelinating event: _____
Type: Relapsing-remitting _____ Secondary-progressive with relapses _____ Primary-progressive _____
 Secondary-progressive without relapses _____ Clinically Isolated Syndrome (CIS) _____ Progressive-relapsing _____
Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):
 Prior therapies: _____ Reason for discontinuation: _____
 Other: _____

Date Shipment Needed: _____ **Ship to:** **Patient** **Physician/Clinic**

PRESCRIPTION INFORMATION OR ATTACH RX

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
Copaxone	20mg	Inject 20mg SQ Daily Other:	1 kit=30 PFS	
Avonex PFS Avonex SDV Avonex Pen	30mcg	Inject 30mcg IM once weekly Titration dosing (Available only for SDV or for PFS using AVOSTARTGRIP™ Titration Kit) Week 1: Inject 7.5 mcg (0.25 mL) IM; Week 2: Inject 15 mcg (0.5 mL) IM; Week 3: Inject 22.5 mcg (0.75 mL) IM; Week 4: Inject 30 mcg (1 mL) IM Other:	1 kit=4 PFS 1 kit=4 SDV 1 kit=4 pens	
Betaseron	0.3mg	Titration Dose Per Package Insert Weeks 1-2: 0.0625 mg/0.25 mL SQ every other day; Weeks 3-4: 0.125 mg/0.5 mL SQ every other day; Weeks 5-6: 0.1875 mg/0.75 mL SQ every other day; Week 7 +: 0.25 mg/1 mL SQ every other day No Titration Dose: 0.25 mg/1 mL SQ every other day	1 kit=15 PFS	
Rebif Titration Pack		Weeks 1-2: Inject 4.4 mcg (0.1 mL) SQ three times weekly; Weeks 3-4: Inject 11 mcg (0.25 mL) SQ three times weekly Weeks 1-2: Inject 8.8 mcg (0.2 mL) SQ three times weekly; Weeks 3-4: Inject 22 mcg (0.5 mL) SQ three times weekly Other:	1 kit = 6 x 8.8 mcg/0.2 mL PFS and 6 x 22 mcg/0.5 mL PFS	
Rebif/Rebiodose Titration Pack		Weeks 1-2: Inject 8.8 mcg (0.2 mL) SQ three times weekly; Weeks 3-4: Inject 22 mg (0.5 mL) SQ three times weekly	1 kit = 6 x 8.8 mcg/0.2 mL autoinjectors and 6 x 22mcg/0.5 mL autoinjectors	
Rebif PFS Rebif/Rebiodose	22mcg/0.5mL	Inject 22 mcg SQ three times weekly Other:	1 kit = 12 x 22 mcg/0.5 mL PFS 1 kit = 12 x 22 mcg/0.5 mL single-use autoinjectors	
Rebif PFS Rebif/Rebiodose	44 mcg/0.5mL	Inject 44 mcg SQ three times weekly Other:	1 kit = 12 x 22 mcg/0.5 mL PFS 1 kit = 12 x 44 mcg/0.5 mL single-use autoinjectors	
OTHER (PLEASE SPECIFY):				

I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies and to coordinate/receive patient lab values.

Patient is interested in Patient Support Programs as necessary/applicable

Ancillary kits and supplies provided as necessary/applicable

Doctor/Prescriber Signature – Dispense as Written

Date

Doctor/Prescriber Signature – Substitution Permissible

Date