

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – OR – Send a copy of the patient’s prescription/insurance cards (front & back)		
Primary Insurance: _____ City, State, Zip: _____ Plan #: _____ Group #: _____ Phone: _____	RX Card (PBM): _____ BIN: _____ PCN: _____ City, State, Zip: _____ Group #: _____ Phone: _____	
CLINICAL INFORMATION		
Primary ICD-10 code: _____ Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No Expected date of first/next injection: _____ Agency nurse to visit home for injection: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NKDA <input type="checkbox"/> Known drug allergies: Concurrent Meds: _____ Date of last injection (if relevant): _____ Agency name & telephone: _____	
(DRUG NAME) ORDERS – this section may not be needed		
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Infusion/Injection: _____		
Medication	Directions	Quantity/Refills
<input type="checkbox"/> Copaxone® 20mg PFS <input type="checkbox"/> Copaxone® 40 mg PFS	<input type="checkbox"/> Inject 20mg subcutaneously daily. <input type="checkbox"/> Inject 40mg subcutaneously three times a week. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply (1 kit/30 syr) <input type="checkbox"/> 90-day supply (3 kits/90 syr) Refills: _____ <input type="checkbox"/> 28-day supply (1 kit/12 syr) <input type="checkbox"/> 84-day supply (3 kits/36 syr) Refills: _____
<input type="checkbox"/> Glatiramer acetate or Glatopa	<input type="checkbox"/> Inject 20mg subcutaneously daily. <input type="checkbox"/> Inject 40mg subcutaneously three times a week. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply (1 kit/30 syr) <input type="checkbox"/> 90-day supply (3 kits/90 syr) Refills: _____ <input type="checkbox"/> 28-day supply (1 kit/12 syr) <input type="checkbox"/> 84-day supply (3 kits/36 syr) Refills: _____
Pre-medication: _____		
SIGNATURE		
X _____ <div style="text-align: center;">Prescriber Signature</div>		Date: _____

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