

Please complete the form, print and submit order by FAXING to: **877.645.7514**

Date Shipment Needed _____ ☐ Deliver to PHYSICIAN/CLINIC ☐ Deliver to PATIENT RX: ☐ New ☐ Refill

Patient Information

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip Code _____

Shipping Address (if different from above) _____

Home Phone _____ Work / Mobile Phone _____

Date of Birth _____ Social Security Number _____ ☐ Male ☐ Female Weight _____ lbs. Recorded Date _____

Allergies _____

Primary Caregiver _____ Phone _____

Emergency Contact _____ Phone _____

Insurance Information (Please complete OR fax copy of insurance card – front and back)

Primary Insurance _____ Phone _____

Name / SSN of Insured _____ ID Number _____ Group Number _____

Secondary Insurance _____ Phone _____

Name/SSN of Insured _____ ID Number _____ Group Number _____

Other Insurance / Prescription Drug Vendor (Rx BIN#) _____

Facility Information

Prescriber Information

Contact

Facility: _____ Prescriber: _____ NPI: _____ Contact: _____

Address: _____ Phone / Fax: _____

Clinical & Prescription Information

Please FAX recent clinical notes, labs, tests with the Rx to expedite the Prior Authorization

Diagnosis _____ ICD9 Code _____

Has patient previously been treated for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

of Relapses in past year _____

Will patient discontinue therapy prior to starting new therapy? ☐ Yes ☐ No

Discontinuation Date _____

Prior Failed Medication (Medication, Duration of Treatment, Reason for d/c) _____

Is patient pregnant, nursing or planning pregnancy? ☐ Yes ☐ No

Last MRI Date _____ Any MRI Changes? ☐ Yes ☐ No

Injection Training Needed by Amber Pharmacy? ☐ Yes ☐ No

Novantrone: Is patient's LVEF <50%? ☐ Yes ☐ No

What is lifetime (cumulative) Novantrone dose (mg/m2)? _____

Copy of last CBC with differential: _____

☐ Serum Creatine _____ ☐ Creatinine Clearance _____

Medication	Dose/Strength	Sig	Qty.	Refills
☐ Avonex®	☐ 30mcg Prefilled Syringe #4 ☐ 30mcg Pen #4	☐ Inject 30mcg IM once weekly	4 week supply	
☐ Betaseron®	☐ 0.3mg vial	☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ Maintenance Dose: 0.25mg /1ml subcutaneously QOD ☐ Other:	4 week supply	
☐ Copaxone®	☐ 20mg Prefilled Syringe	☐ 20mg SQ QD	4 week supply	
☐ Extavia®	☐ 0.3mg vial	☐ Maintenance Dose: 0.25mg /1ml subcutaneously QOD ☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ Other:	4 week supply	
☐ Rebif®	☐ Titration Pack (8.8mcg/22mcg) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe ☐ Rebiodose Titration Pack ☐ Rebiodose 22mcg auto-injector ☐ Rebiodose 44mcg auto-injector	☐ Inject 8.8mcg subcutaneously three times a week for weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) ☐ Maintenance: Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) ☐ Maintenance: Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) ☐ Other:	4 week supply	
☐ Other				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature _____ Date _____

☐ I authorize Amber Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature _____ DEA #: _____ Date _____