



PharmaCare Specialty Pharmacy Neurology Enrollment Form

Phone: 800-990-9247
Please fax to 800-447-3694

Ship To: Patient
 Physician/Clinic

PATIENT INFORMATION:

See attached demographic sheet

Date: _____ Patient SS# _____ Male Female
Patient's First Name: _____ Patient's Last Name: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
DOB: _____ Caregiver: _____ Allergies: _____
ICD-9 Code: _____ Secondary ICD-9 Code: _____

INSURANCE INFORMATION (fill out entirely OR fax copy of patient's insurance card both sides)

Primary Insurance: _____ Secondary Insurance: _____
Insured: _____ Insured: _____
Phone: _____ Phone: _____
Policy #: _____ Policy #: _____
Group: _____ Group: _____

Prescription Information

Drug Name	Strength	SIG/Directions	Other SIG	Quantity	# of Refills
<input type="checkbox"/> Copaxone	20mg	Inject 20mg SQ daily	_____	1 kit=30 prefilled syringes	_____
<input type="checkbox"/> Autoject 2 for glass syringe injection device/PRN (to be provided by Shared Solutions)					
<input type="checkbox"/> Enroll in Shared Solutions/Needs Nurse training					
<input type="checkbox"/> Avonex PFS	30mcg	Inject 30mcg IM once weekly	_____	1kit=4 prefilled syringes	_____
<input type="checkbox"/> Avonex SDV	30mcg	Inject 30mcg IM once weekly	_____	1kit=4 single dose vials	_____
<input type="checkbox"/> Enroll in MS ActiveSource/Needs Nurse training					
<input type="checkbox"/> Betaseron	0.3mg	_____	_____	1kit=15 prefilled syringes	_____
<input type="checkbox"/> Sig. Titration Per Package Insert: _____					
Weeks 1-2		0.0625mg/0.25ml SQ QOD			
Weeks 3-4		0.125mg/0.50ml SQ QOD			
Weeks 5-6		0.1875mg/0.75ml SQ QOD			
Weeks 7+		0.25mg/1ml SQ QOD			
<input type="checkbox"/> No Titration Dose: 0.25mg (1ml) SQ QOD					
<input type="checkbox"/> Other Sig: _____					
<input type="checkbox"/> Enroll in MS Pathways/Needs nurse training					
<input type="checkbox"/> Rebif Titration Pack		Inject 8.8mcg (0.2ml) SQ three times weekly for week 1-2 and 22mcg (0.5ml) SQ three times weekly for week 3-4	_____	1kit=6x8.8mcg syringes and 6x22mcg syringes	_____
<input type="checkbox"/> Rebif	22mcg/0.5ml	Inject 8.8mcg (0.2ml) SQ three times weekly for week 1-2 Inject 22mcg (0.5ml), SQ three times weekly for week 3-4	_____	_____	_____
<input type="checkbox"/> Rebif	44mcg/0.5ml	Inject 44mcg (0.5ml) SQ three times weekly	_____	_____	_____
<input type="checkbox"/> Rebif	_____	_____	_____	_____	_____
<input type="checkbox"/> Enroll in MS LifeLines/Needs nurse training					
<input type="checkbox"/> Botox	100units/vial	_____	_____	_____	_____
<input type="checkbox"/> Myobloc	5000units/ml	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____	_____

DATE SHIPMENT NEEDED: _____ TODAY'S DATE: _____
PHYSICIAN'S NAME (Please Print): _____ CONTACT PERSON: _____
PHYSICIAN'S PHONE NUMBER: _____ PHYSICIAN'S FAX NUMBER: _____
OFFICE ADDRESS: _____
LICENSE # _____ UPIN # _____ MEDICAID PROVIDER # _____
PHYSICIAN'S SIGNATURE: _____ M.D. DEA# _____

NO SUBSTITUTION - Substitution Permissible unless practitioner checks this box

I authorize PharmaCare Specialty Pharmacy to enroll me in the manufacturer's patient support program corresponding with my prescribed course of therapy with (Shared Solutions for Copaxone at Teva Neuroscience) _____ (initial), (MS ActiveSource for Avonex by Biogen-Idec) _____ (initial), MS PathWays for Betaseron by Berlex _____ (initial), or MS LifeLines for Rebif at Seroon _____ (initial) for purposes of receiving additional services such as, but not limited to, injection training. I further authorize PharmaCare to release and communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to; coordinate the delivery of products and services available through the patient support program, aggregate de-identified data for market analysis and provide educational information regarding multiple sclerosis therapies. I understand that I may revoke this authorization anytime in writing by sending a letter to PharmaCare Specialty Pharmacy, Private Office, 600 Penn Center Blvd., Pittsburgh, PA 15235. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the pharmacy, however, I will not be enrolled in the patient support program(s) listed above. A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Signature _____ Date _____

Important note: This form is intended only for the named addressee and may contain material that is confidential, privileged, proprietary or exempt for disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named address, except by express authority of the sender to the named addressee.