

DATE: _____ NEEDS BY DATE: _____
SHIP TO: PATIENT OFFICE OTHER _____

Patient Information

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

Clinical Information

Diagnosis Code:
 G35 Multiple Sclerosis Other: _____
 Relapsing Remitting Primary Progressive Secondary Progressive
 Progressive Relapsing

Drug Allergies: _____

Provider Information

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

History:
 • Has the patient been previously treated for this condition? No Yes
 If Yes, Medication failed: _____
 • Is the patient currently on therapy? No Yes
 If Yes, Medication failed: _____
 • Will patient stop taking current therapy before starting new therapy? Yes No
 • How long will the patient wait before starting the new therapy? _____
 • Are there other medications patient currently taking?
 Please list: _____

Product	Quantity	Prescription Information	Supply	Refills
<input type="radio"/> Avonex®	30mcg <input type="radio"/> PFS <input type="radio"/> PEN <input type="radio"/> Pwd	<input type="radio"/> Inject 30mcg intramuscularly once weekly <input type="radio"/> Other dosing: _____	1 kit	
<input type="radio"/> Betaseron®	0.3mg Vial	<input type="radio"/> Initial Week 1&2: 0.0625mg (0.25ml), Week 3&4: 0.125mg (0.5ml), Week 5&6: 0.1875mg (0.1875mg (0.75ml), Week 7+: 0.25mg (1ml) SQ every other day <input type="radio"/> Maintenance Dose: Inject 0.25mg (1ml) SQ every other day	1 kit 1 kit	
<input type="radio"/> Copaxone®	<input type="radio"/> 20mg PFS <input type="radio"/> 40mg /mL PFS	<input type="radio"/> Inject 20mg subcutaneously daily <input type="radio"/> Inject 40mg subcutaneously three times a week	1 kit 1 kit	
<input type="radio"/> Extavia®	0.3mg Vial	<input type="radio"/> Initial Week 1&2: 0.0625mg (0.25ml), Week 3&4: 0.125mg (0.5ml), Week 5&6: 0.1875mg (0.1875mg (0.75ml), Week 7+: 0.25mg (1ml) SQ every other day <input type="radio"/> Maintenance Dose: Inject 0.25mg (1ml) SQ every other day	1 kit 1 kit	
<input type="radio"/> Gilenya®	0.5mg Capsule	Take 1 capsule PO daily	1 month supply	
<input type="radio"/> Glatopa®	20mg PFS	Inject 20mg SQ daily	1 kit	
<input type="radio"/> Plegriidy®	<input type="radio"/> Starter Pack <input type="radio"/> PEN <input type="radio"/> PFS <input type="radio"/> 125mcg PFS <input type="radio"/> 125mcg PEN	<input type="radio"/> Inject 63mcg SQ on day-1, then 94mcg SQ on day -15, then 125mcg SQ on day-29 <input type="radio"/> Inject 125mcg SQ every 14 days	1 kit 1 kit	
<input type="radio"/> Rebil®	<input type="radio"/> Titration Rebidose <input type="radio"/> Titration Pack <input type="radio"/> 22mcg/0.5mL Rebidose <input type="radio"/> 22mcg/0.5mL PFS <input type="radio"/> 44mcg/0.5mL Rebidose <input type="radio"/> 44mcg/0.5mL PFS	<input type="radio"/> Titration Dose: wk 1&2: inject 8.8mcg SQ TIW; wk 3& 4: inject 22mcg SQ TIW; wk 5+: inject 44mcg SQ TIW <input type="radio"/> Maintenance Dose: Inject mcg SQ TIW	1 kit 1 kit	
<input type="radio"/> Tecfidera®	<input type="radio"/> Titration Starter Pack Caps <input type="radio"/> 240mg <input type="radio"/> 120mg	<input type="radio"/> Titration Dose: Take 120mg PO BID x 7 days, then take 240mg PO BID thereafter <input type="radio"/> Take 240mg capsule PO Twice Daily <input type="radio"/> Take 120mg capsule PO Twice Daily <input type="radio"/> Other _____	1 kit 1 month supply 1 month supply	
<input type="radio"/> Radicava	<input type="radio"/> 30mg/100ml sol	<input type="radio"/> 60 mg IV once daily for 14 days initially followed by 14 days off <input type="radio"/> 60 mg IV for 10 days out of 14, followed by 14 days off.	14 day supply	

Other _____

PLEASE FAX COPY OF : 1) PRESCRIPTION CARD FRONT & BACK 2) CLINICAL NOTES 3) MEDICAL CARD FRONT & BACK

By signing this form and utilizing our services, you are authorizing Eventus Rx, Inc to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date
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