# CoxHealth at Home

## Multiple Sclerosis
## Self-Injectable Agents (drugs E-Z)

**PHONE: 1-855-419-4663**
**FAX: 1-417-269-0692**

### Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SSN: _____
Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
**Please fax a copy of front and back of the insurance card(s).**

### Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ❑ First Fill ❑ Always Never

### Clinical Information (Please fax all pertinent clinical and lab information)

**Diagnosis:** ❑ G35 (Multiple Sclerosis) ❑ _____ Diagnosis Date: _____
Type: ❑ Clinically isolated syndrome ❑ Relapsing-remitting ❑ Secondary-progressive ❑ Primary-progressive ❑ Progressive-relapsing
Hepatic Impairment present: ❑ Yes ❑ No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____
Pre-existing hepatic conditions: ❑ HBV ❑ HCV ❑ _____ TB Test: ❑ Positive ❑ Negative Test date: _____

| Prior Therapy ❑ Yes ❑ No | Reason for Discontinuation of Therapy | Approximate Start Date | Approximate End Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

### Prescription

| Prescription | | Quantity | | Refill |
|---|---|---|---|---|
| ❑ Extavia® (interferon beta-1b) | ❑ Week 1-2: Inject 0.0625 mg (0.25 mL) SQ every other day; Week 3-4: Inject 0.125 mg (0.5 mL) SQ every other day. | 15 x 0.3 mg | Vials | 0 |
| | Week 5-6: Inject 0.1875 mg (0.75 mL) SQ every other day; Week 7-onward: Inject 0.25 mg (1 mL) SQ every other day. | | | 0 |
| | ❑ Inject 0.25 mg (1 mL) SQ every other day | 15 x 0.3 mg | Vials | _____ |
| ❑ Rebif® (interferon beta-1a) | ❑ Week 1-2: Inject 4.4 mcg (0.1 mL) SQ three times per week; Week 3-4: Inject 11 mcg (0.25 mL) SQ three times per week. | 6 x 8.8 mcg<br>6 x 22 mcg | ❑ PFS<br>❑ Autoinjector | 0 |
| | Week 5 and thereafter: Inject 22 mcg SQ three times per week | 12 x 22 mcg | ❑ Autoinjectors<br>❑ PFS | _____ |
| | ❑ Week 1-2: Inject 8.8 mcg (0.2 mL) SQ three times per week; Week 3-4: Inject 22 mcg (0.5 mL) SQ three times per week. | 6 x 8.8 mcg<br>6 x 22 mcg | ❑ Autoinjectors<br>❑ PFS | 0 |
| | Week 5 and thereafter: Inject 44 mcg SQ three times per week | 12 x 44 mcg | ❑ Autoinjectors<br>❑ PFS | _____ |
| ❑ Plegridy® (peginterferon beta-1a) | ❑ Inject 63 mcg SQ on day 1; then inject 94 mcg on day 15 | 1 x 63 mcg<br>1 x 94 mcg | ❑ Pens<br>❑ PFS | 0 |
| | ❑ Inject 125 mcg SQ day 29 and every two weeks thereafter | 2 x 125 mcg | ❑ Pens<br>❑ PFS | _____ |

For additional MS Injectables, see other referral form MS Injectable (A-D)

Injection Training Provided by: ❑ Prescriber's Office ❑ CoxHealth at Home ❑ Training not needed ❑ Other: _____

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home

CoxHealth



Last Reviewed: 12-15-2020