MS LifeLines®

Fax this form to: 1-866-227-3243

Call us toll free: 1-877-447-3243

Rebif® *(interferon beta-1a)*

Prescription and Service Request Form

Physician ID# _____

STEP 1: Complete Physician Information

Prescriber's Name: _____

Contact Name: _____

Office/Clinic/Institution: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Tax ID #: _____

State Medical License #: _____

DEA #: _____ UPIN #: _____

NPI #_____

STEP 2: Complete Patient Information

Patient Name:_____ Gender: ☐ M ☐ F

SS #:_____ DOB:_____

Home Address:_____

City:_____ State:____ Zip:_____

Home Phone:_____ Work Phone: _____

Cell Phone: _____ Preferred Phone: ☐ Home ☐ Work ☐ Cell

Okay to leave a message at home: ☐ Yes ☐ No

At work: ☐ Yes ☐ No On Cell: ☐ Yes ☐ No

Email: _____

Language Preference: ☐ English ☐ Spanish ☐ Other:_____

STEP 2A: Patient Authorization

I have read and understand the **Authorization to Use and Disclose Health and Other Personal Information** and agree to the terms on the following page.

Patient Name (please print): _____ **Signature of patient** (or personal representative):_____

Date: _____ **Authority/relationship of personal representative** (if applicable):_____

STEP 2B: Check (☑) Here to Opt out of MS LifeLines Services

☐ I do not wish to receive marketing materials from MS LifeLines

☐ I do not wish to have MS LifeLines nurse provide injection training

DELIVERY METHOD: (Choose One)

☐ **Rebif® Rebidose®** *(interferon beta-1a)*

☐ **Prefilled Syringe/Rebiject II®**

STEP 3: Check (☑) Here for Start-up Rx and Titration Orders

Check box(es):

☐ Start ☐ Dose change

☐ Restart ☐ Delivery method change

☐ Refill ☐ Insurance change

☐ Nurse training visit only

☐ MS LifeLines® services (patient has medication)

Rx: Rebif® *(interferon beta-1a)* Rx info must be completed if home visit is ordered.

*Please note if intended prescribed dose is 22 mcg Rebif® Rebidose®, please fax separate form for Prefilled Syringe Titration Pack.

☐ **Dispense Titration Pack (12)** SIG: 8.8 mcg subcutaneous 3 times weekly – weeks 1-2
22 mcg subcutaneous 3 times weekly – weeks 3-4

Pre- / post-treatment instructions: _____

Preferred pharmacy: AcariaHealth phone: 877.928.5120 fax: 877.928.5121

STEP 3A: Check (☑) Here for Ongoing Rx

☐ Dispense 1 box (12) Refills: _____
44 mcg/0.5 mL subcutaneous 3 times weekly
or
☐ Dispense 3 boxes (36) Refills: _____
44 mcg/0.5 mL subcutaneous 3 times weekly

☐ Dispense 1 box (12) Refills: _____
22 mcg/0.5 mL subcutaneous 3 times weekly
or
☐ Dispense 3 boxes (36) Refills: _____
22 mcg/0.5 mL subcutaneous 3 times weekly

STEP 4: Complete Insurance

☐ No Insurance ☐ Insurance change

☐ Insurance card/cards attached (front and back)

Primary Insurance:_____

Cardholder: _____ Phone #:_____

Cardholder Employer: _____ Does this patient have a separate pharmacy benefit card? ☐ Yes

Employer Phone: _____ Name of Pharmacy Benefit Manager:_____

ID #: _____ Group #: _____ ID #: _____ Group #: _____

STEP 5: Complete and Sign Statement of Medical Necessity

PRIMARY DIAGNOSIS: ICD-10 code G35 ICD-9 code CM340

I certify the prescribed therapy is medically necessary for the treatment of relapsing forms of Multiple Sclerosis, and that this information is accurate to the best of my knowledge.

Patient was previously treated with:_____

I authorize EMD Serono, Inc. to be my designated agent (1) to provide any information on this form to the insurer of the above named patient and (2) forward the above prescription by fax or by other mode of delivery to the pharmacy chosen by the above named patient.

Physician's Signature: _____ **Date:**_____

CONFIDENTIAL

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Authorization to Use and Disclose Health and Other Personal Information

I authorize my physician and their staff to disclose my health and other personal information, including, but not limited to, the information on this form, to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to: (1) facilitate the filling of my prescription for and the delivery and administration of Rebif®; (2) assist me in obtaining insurance coverage for Rebif; (3) contact me by mail, e-mail, and/or telephone to enroll me in, and administer, programs that provide Rebif support services; (4) provide me with free educational information and materials; and/or (5) conduct surveys to measure my satisfaction with Rebif and Rebif support services.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act) or state privacy laws and may be further disclosed to others. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive Rebif, my treatment, payment for treatment, eligibility for or enrollment in health benefits, but it will limit my ability to receive support services for Rebif.

I understand that this authorization will remain in effect for ten years, or such shorter period as may be required by state law, from the date of my signature, unless I revoke it earlier by contacting EMD Serono in writing at MS LIfeLines®, One Technology Place, Rockland, MA 02370. If I revoke this authorization, EMD Serono and any Third Parties who are notified of my revocation will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that I have agreed to and that are described in this authorization may be reduced at any time, without prior notification. However, if any services are added, EMD Serono will obtain my authorization to receive any such additional services.

I understand that certain Third Parties may receive compensation in exchange for their disclosure of my information to EMD Serono.

I also understand that I have the right to receive a copy of this authorization.

Please sign in the space in Step 2A on the preceding page to authorize your consent.

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