







MULTIPLE SCLEROSIS SELF INJECTABLES
Patient Enrollment/Prescription Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION			
Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian	Day Telephone	Night Telephone	
Emergency Contact	Relationship	Telephone	

2 PRESCRIBER INFORMATION			
Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	

Fax Completed Form to:
Fax Number: 800-218-3221 
Phone Number: 866-843-3604 

3 Department of Vermont Health Access PRESCRIPTION MULTIPLE SCLEROSIS SELF INJECTABLES	
Patient Diagnosis:	
Product:	
<input type="checkbox"/> Avonex 30 mcg/0.5 ml Prefilled Syringe (4 per box) <input type="checkbox"/> Avonex 30 mcg Kit (Single Dose Vials) (4 per box) <input type="checkbox"/> Betaseron 0.3 mg Prefilled Syringe <input type="checkbox"/> Copaxone 20 mg Prefilled Syringe (30 per kit) <input type="checkbox"/> Rebif Titration Pack X 1 (Therapy initiation ONLY-No Refills) (contains 6 - 8.8 mcg and 6 – 22 mcg Prefilled Syringes) <input type="checkbox"/> Rebif 22 mcg/0.5 ml Prefilled Syringes <input type="checkbox"/> Rebif 44 mcg/0.5 ml Prefilled Syringes	
(Please Note: This form not to be used for Tysabri PA request or ordering)	
Quantity:	Refills:
Dose / Route/ Frequency Instructions (Sig):	
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic	
<input type="checkbox"/> Needles/syringes: quantity sufficient for drug supply with refills as above	
Prescriber's Signature: _____ Date: _____	