MS LifeLines™ 1-877-44Rebif (1-877-447-3243)

Prescription and Service Request Form

Form Effective 3/1/05

Rebif® (interferon beta-1a) sc injection

Fax this form to: 1-866-22Rebif (1-866-227-3243)

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#: ______

STEP 2: Check (✔) here for Start-up Rx & Titration Orders:

Check one:

- ❑ New Patient
- ❑ Restart
- ❑ Rebiject II & Injection training only *(patient has Rx)*

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

❑ Dispense Rebif® 1 **Titration Pack** (12 syringes) Refills: 0

SIG: 8.8 mcg sub-q 3 times weekly - weeks 1-2
22 mcg sub-q 3 times weekly - weeks 3-4
44 mcg sub-q 3 times weekly - weeks 5+

or

❑ Dispense Rebif® ___ box (12 syringes) **22 mcg**/0.5ml Refills: ___

Other SIG: ______

STEP 2A: Check (✔) here for Ongoing Rx:

❑ Dispense Rebif® 1 box (12 syringes) **44 mcg**/0.5ml sub-q 3 times weekly Refills: 11

or

❑ Dispense Rebif® 3 box(es) (12 syringes/box) **44 mcg**/0.5ml sub-q 3 times weekly Refills: 3

STEP 2B: Check here for Rebiject II Order and Injection Training:

❑ Rebiject II™ device – To be used as directed. Refills: 0

❑ Skilled home nursing visits to provide injection training.

Preferred Agency: ______

❑ Patient to be trained by the physician's office.

STEP 3: Complete and Sign Statement of Medical Necessity:

PRIMARY DIAGNOSIS: ICD-9 code CM 340 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: ______

Reason for discontinuation: ______

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

Physician's Signature: ______ **Date:** ______

STEP 4: Complete Patient Information

Patient Name: ______

SS#: ______ DOB: ___/___/___ Sex: ❑ Male ❑ Female

Home Address: ______

City: ______ State: ______ Zip: ______

Home Phone: ______ Work Phone: ______

Cell Phone: ______ Preferred Phone: ❑ home ❑ work ❑ cell

Okay to leave message at home: ❑ Yes ❑ No / At work: ❑ Yes ❑ No / On Cell: ❑ Yes ❑ No

E-mail: ______

Allergies: ______

STEP 5: Complete Insurance *or attach a copy of patient's insurance card, front & back)*

Primary Insurance: ______

Cardholder: ______

ID#: ______ Group #: ______

Phone #: ______

Does this patient have a pharmacy benefit card? ❑ Yes ❑ No

Name of Pharmacy Benefit Manager: ______

ID#: ______ Group #: ______

Phone#: ______

STEP 6: Patient Signs Consent and HIPAA Authorization

I authorize Serono, Inc., its copromote party, or their personnel and agents to contact my healthcare provider, pharmacy, insurance company and any third-party payers and for them to release and disclose to such parties all my medical records, insurance and third-party payer information. Serono will use and may disclose to third parties working with Serono this information and other information I give to Serono and such third parties to help me with reimbursement, facilitate dispensing of Rebif and my participation in other programs I choose. I authorize Serono to send, via mail or fax, my prescription to the pharmacy of my choosing. This authorization has no expiration date. I understand that: I can revoke this authorization by notifying Serono at MS Lifelines™ in writing; once my information is disclosed to third-parties under this authorization it may not be protected (but Serono takes steps to safeguard the confidentiality of my information); I can refuse to sign this form (but then I won't get help with reimbursement, prescription facilitation or might not be able to participate in some programs).

Please check the box below so you don't miss out on up-to-date information about MS and Rebif®

❑ Please contact me in the future regarding up-to-date information on Rebif®, MS and additional Serono programs and services.

Patient's Signature: ______ Date: ______

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