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: _____

Electronically transmitted Rx valid for one year.

CONFIDENTIAL

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