MULTIPLE SCLEROSIS

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Male/Female:	
Home Address:	City:	State:	Zip:
DOB:	Height:	Weight:	Allergies:
Phone (H):	Phone (C):	Phone (W):	
Email: _____ SSN #: _____			

**Complete and Attach Copies of card*

Insurance

Primary Insurance:	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity **Date:**

Has patient been treated previously for this condition? ___Y ___N Medications failed:_____

Is patient currently on therapy? ___Y ___N Type/Medications:_____

Will patient stop taking the above medication(s) before starting the new medication? ___Y ___N

If yes, how long should the patient wait before starting the new medication?_____ *Other Current Medications:*_____

Diagnosis:

☐ Multiple Sclerosis 340 ☐ Other_____

Type of MS:

☐ Primary Progressive ☐ Secondary Progressive ☐ Relapsing – Remitting ☐ Other:_____

Prescription

Medication	Strength	Directions	Qty	Refills
☐ Avonex® Vials	30 mcg	☐ IM Weekly		90 day
☐ Avonex Prefilled Syringes		☐ Alternate Dosing:_____		
☐ Betaseron®	0.25 mg (1ml)	☐ SQ every other day		90 day
☐ Extavia®	20 mg	☐ Alternate Dosing:_____		90 day
☐ Copaxone®		☐ SQ every day ☐ Alternate Dosing:_____		
☐ Rebif® Starter Pack	*22 mcg Titration Schedule*	*44 mcg Titration Schedule*		
	☐ Week 1-2: 4.4 mcg (0.1ml) SQ TIW	☐ Week 1-2: 8.8 mcg (0.1ml) SQ TIW		30 day
	☐ Week 3-4: 11 mcg (0.25ml) SQ TIW	☐ Week 3-4: 22 mcg (0.25ml) SQ TIW		30 day
	☐ Week 5+: 22 mcg (0.5ml) SQ TIW	☐ Week 5+: 44 mcg (0.5ml) SQ TIW		30 day
☐ Rebif®	☐ 22 mcg Maintenance	☐ TIW (48 hours apart)		30 day
	☐ 44 mcg Maintenance	☐ Alternate Dosing:_____		30 day
☐ Gilenya®	0.5 mg	☐ Oral 0.5 mg daily		Other____
		☐ Alternate Dosing:_____		
☐ Other:				

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____ *All the supplies including syringes and needles will be dispensed if requested.*

Physician Signature: _____ ☐ DAW (Dispense as Written) Date:_____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

Patient Signature:_____ Date:_____