214 E. Fulton St. Grand Rapids, MI 49503
Phone: 616.301.8200 Toll Free Phone: 866.356.6048
Fax: 616.301.8201 **Toll Free Fax: 877.356.6048**

Copaxone, Rebif

Patient Information

Date:________________________ Patient SS#:_________________________ ☐ Male ☐ Female
Patient's First Name:__________________________________ Patient's Last Name:____________________________________
Address:____ City:_______________________ State:________ Zip:__________
Home Phone:________________________ Work Phone:________________________ Cell Phone:_________________________
DOB:______________________________ Weight:___________________ kgs or lbs (circle one) Recorded Date:____________
Caregiver:________________________ Allergies:____

Insurance Information (fill out entirely OR **fax copy of patient's insurance card - both sides**)

Employer:____ Secondary Insurance:_______________________________________
Insured:____ Insured:____
Phone:____ Phone:____
Policy #:____ Policy #:____

Medication

MEDICATION	DOSE	ROUTE	FREQUENCY	LENGTH	CYCLE	REFILLS
☐ Copaxone	_________	_________	_________	_________	_________	#_____X _____MONTHS
☐ Rebif	_________	_________	_________	_________	_________	#_____X _____MONTHS
☐ ______________________	_________	_________	_________	_________	_________	#_____X _____MONTHS
☐ ______________________	_________	_________	_________	_________	_________	#_____X _____MONTHS
☐ ______________________	_________	_________	_________	_________	_________	#_____X _____MONTHS
☐ ______________________	_________	_________	_________	_________	_________	#_____X _____MONTHS

PRIMARY DIAGNOSIS CODE: ____________________________ SECONDARY DX CODE: ________________________________

ADDITIONAL NOTES:

____

____

HEALTH PLAN or PBM Authorization Number (if required)

____

Today's Date:_________________ Date Shipment Needed:_________________ Ship to: ______Patient _____Physician/Clinic
Ship to Other:____

Physician's Name (please print):____ Contact Name:_____________________
Phone #:_____________________________ Fax #:_____________________________ NPI #:______________________________
Office Address:____ City:______________________ State:_______ Zip:__________

Physician's Signature:____ DEA #:_______________________

I authorize Diplomat Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.