Rebif® (interferon beta-1a) PRESCRIPTIONS AND SERVICE REQUEST FORM

MSLifeLines®

Send Fax
1-866-227-3243

Questions? Call Us
1-877-447-3243

MS LifeLines Service Offerings *(Please select all that may apply)*

☐ Benefits Verification ☐ Financial Assistance ☐ Nursing Support

1 | Patient Information

First Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Gender (optional) _____

Home Address _____

City _____ State _____ Zip _____

Preferred Phone Number _____ ☐ Home ☐ Work ☐ Cell

Okay to leave voicemail? ☐ Yes ☐ No Preferred Language _____

Email _____

Preferred Method of Communication
☐ Phone ☐ Email ☐ Text (opt-in below) _____
Cell if not provided above

2 | Patient Authorization

2A | I have read and understand the **Authorization to Use and Disclose Health and Other Personal Information** and agree to the terms on page 3.

SIGNATURE

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE Date

PERSONAL REPRESENTATIVE FULL NAME *(if applicable)*

Authority/relationship of personal representative *(if applicable):*
☐ Legal Guardian
☐ Power of Attorney

2B | ☐ By checking this box, I confirm that I have read and understand the **Opt-in for Marketing Text Messages** and agree to the terms on page 3.

3 | Patient Insurance Information *(Please include a copy of both sides of the insurance card)*

Type of Insurance
☐ Employer ☐ Medicaid ☐ Medicare ☐ Healthcare Exchange
☐ No Insurance ☐ Other: _____

Has prior authorization (PA) been initiated? ☐ Yes ☐ No
If "Yes", PA status: ☐ Approved ☐ Denied ☐ In Progress

Primary Insurance _____

Cardholder Name (if different than patient) _____

ID # _____ Group # _____ Phone # _____

Prescription Insurance _____

Rx ID # _____ Rx Group # _____ Rx BIN _____

Rx PCN _____ Phone # _____

4 | Patient Medical History

Last Disease-Modifying Drug (DMD) _____ Date of Last Dose _____

Previous MS DMDs _____

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5 | Prescriber Information

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

NPI # _____ Tax ID # _____

State License # (PR only) _____

Office/Clinic/Institution Name _____

Office Contact Name _____

Office Contact Phone _____ Office EXT _____

Office Fax _____

Office Contact Email _____

6 | Prescription Information

Patient Name _____ Patient Date of Birth _____

Preferred Specialty Pharmacy _____

Pharmacy Phone _____

Pharmacy Fax _____

Prescription already sent? ☐ Yes ☐ No

6A | Delivery Method *(Select One)*

☐ **Rebif® Prefilled Syringe**

☐ **Add Device: Rebiject II® autoinjector**
(Optional, for use with Rebif prefilled syringe)

☐ **Rebif® Rebidose®** *(interferon beta-1a)*

6B | Titration Rx *(Select One)*

☐ **No Titration**

☐ **Titration Pack (12 injections)**
SIG: Inject 8.8 mcg SQ 3 times weekly – weeks 1-2
SIG: Inject 22 mcg SQ 3 times weekly – weeks 3-4

6C | Dosages: Choose one option from either the 44 mcg dosage or the 22 mcg dosage

44 mcg *(Select One)*

☐ Dispense 1 box (12) Refills: _____
SIG: Inject 44 mcg/0.5 mL SQ 3 times weekly

☐ Dispense 3 boxes (36) Refills: _____
SIG: Inject 44 mcg/0.5 mL SQ 3 times weekly

— OR —

22 mcg *(Select One)*

☐ Dispense 1 box (12) Refills: _____
SIG: Inject 22 mcg/0.5 mL SQ 3 times weekly

☐ Dispense 3 boxes (36) Refills: _____
SIG: Inject 22 mcg/0.5 mL SQ 3 times weekly

Please list any specific instructions you would like the pharmacy to provide to your patient:

_____

7 | Prescriber Authorization*

DIAGNOSIS: ICD-10 code G35.A (RRMS), G35.C1 (Active SPMS), or G35.D (MS, unspecified)

- I certify the prescribed therapy is medically necessary for the treatment of one of the above-listed diagnoses, and that this information is accurate to the best of my knowledge.
- I authorize EMD Serono, Inc. to be my designated agent (1) to provide any information on this form to the insurer of the above-named patient and (2) to forward the above prescription by any method, under applicable law, to the pharmacy chosen by the above-named patient.
- I hereby certify that my office has obtained HIPAA-compliant authorization from the above-named patient to disclose medical and other protected health information necessary for EMD Serono to provide the services described in the Authorization on the following page, including assisting the patient with obtaining insurance coverage for Rebif.

SIGNATURE

_____ _____ _____

Provider Signature *(Dispense as Written)* *(Substitution Permissible)* **Date**

*Prescribers must review and comply with their state-specific prescription requirements (e.g., e-prescribing mandates, official state prescription forms).

Note: All patients will receive injection training from an MS LifeLines nurse.

Rebif® (interferon beta-1a) PRESCRIPTIONS AND SERVICE REQUEST FORM

AUTHORIZATION TO USE AND DISCLOSE HEALTH AND OTHER PERSONAL INFORMATION

Authorization to Use and Disclose Health and Other Personal Information

I authorize my treating physician(s), pharmacy(ies), health insurance company(ies), prescription drug plan(s), and other parties providing me health care or paying for my health care (collectively, "My Health Care Providers and Plans") to disclose my personal and protected health information ("Health Information") to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono"). My Health Information may include, but is not limited to, information regarding my diagnosis of and treatment for multiple sclerosis ("MS"), information included in a Prescription and Service Request Form, and any other information deemed relevant by My Health Care Providers and Plans that may be considered sensitive or specially protected by law. EMD Serono may use and further disclose my Health Information to My Health Care Providers and Plans or other third parties in order to: (1) enroll me in and administer the MS LifeLines Support Program and contact me by mail, email, or by live call at the telephone number(s) listed below, or to any future telephone number(s) provided by me; (2) conduct a benefits investigation and coordinate my insurance coverage for any prescribed EMD Serono product(s); (3) facilitate the filling of my prescription for and the delivery and administration of that product(s); (4) contact me regarding the MS LifeLines Support Program and conduct quality assurance, surveys, and other internal business activities in connection with the MS LifeLines Support Program; and (5) conduct marketing activities that includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition and/or to conduct market research activities that includes contacting me to participate in focus groups, surveys, or interviews that may be funded or sent by EMD Serono, a MS LifeLines Support Program, or an EMD Serono affiliate.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (eg, the Health Insurance Portability and Accountability Act [HIPAA]) or state privacy laws and may be further disclosed to others. However, I understand that EMD Serono will not release my personally identifiable information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

For more information on your privacy rights and choices, please see EMD Serono's privacy notice at https://www.emdserono.com/us-en/privacy-policy.html.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive any EMD Serono product, my treatment, payment for treatment, eligibility for or enrollment in health benefits, but it will limit my ability to receive MS LifeLines Support Program services. I understand that this authorization will remain in effect for 10 years, or such shorter period as may be required by state law, from the date of my signature unless I revoke it earlier by contacting EMD Serono in writing at EMD Serono & MS LifeLines, 200 Pier 4 Boulevard, Boston, MA 02210. If I revoke this authorization, My Health Care Providers and Plans will stop disclosing this information to EMD Serono, and EMD Serono will stop using and disclosing my information, as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that certain of My Health Care Providers and Plans may receive compensation in exchange for their disclosure of my information to EMD Serono. I also understand that I have the right to receive a signed copy of this authorization.

Please fill in the information listed in Step 2A on Page 1 to authorize your consent.

Opt-In for Automated Marketing Text Messages

I authorize EMD Serono, Inc. (or its agents), to send marketing text messages to the cell phone number(s) listed (or to any future telephone number(s) provided by me to EMD Serono, Inc. or its agents) using an automatic telephone dialing system on a recurring basis. This consent also enables EMD Serono to contact me by text message to provide me with MS LifeLines Support Program services. Signing this consent is not a condition of participating in the MS LifeLines Support Program or purchasing products, goods, or services from EMD Serono. I understand that my mobile phone service provider may charge me fees for texts sent to me, and I agree that EMD Serono will have no liability for the cost of any such calls or texts. At any time, I may withdraw my consent to receive text messages by replying "STOP" via return text message or contacting EMD Serono in writing at EMD Serono & MS LifeLines, 200 Pier 4 Boulevard, MA 02210.

Please check the box listed in Step 2B on Page 1 to authorize your consent.