Fax to: 1-800-775-5834	COPAXONE® (glatiramer acetate injection) PRESCRIPTION AND SERVICE REQUEST FORM SHARED SOLUTIONS®	Phone: 1-800-887-8100

Patient Information
(Please print)
(Please circle preferred phone number)

Name (First, MI, Last, Suffix):				Date of Birth:	Gender: ☐M ☐F
Home Address:					
City:	State:	Zip:	Home Phone:	Cell Phone:	☐Check to opt out of voice message receipt

Allergies:

Email Address:	Previous MS Therapies:
Other Medications:	

Prescriber Information

Physician:		NP/PA *(if prescriber)*:	
Address:	City:	State:	Zip:
Phone:	Fax:	Office/Nurse Contact:	

Insurance Information
(Attach a copy of patient's insurance card, front & back)

Primary Insurance:		Medicare: ☐A ☐B ☐D (attach a copy of red, white & blue Medicare card)
Cardholder:	ID #:	Group #:
Phone:	Does patient have a pharmacy benefit card? ☐Yes ☐No	

Rx Card Name:	ID #:	Rx Group:
Rx Bin:	Rx PCN:	Rx Card Phone:

(✓) Check for Rx(s) Required

☐COPAXONE® 40 mg PRE-FILLED Syringes
Inject 40 mg SQ three (3) times weekly
Dispense: 1 box of 12 syringes (28-day supply)
May dispense up to an 84-day supply at a time.
Refills: x 1 year

OR

☐COPAXONE® 20 mg PRE-FILLED Syringes
Inject 20 mg SQ one (1) time daily
Dispense: 1 box of 30 syringes (30-day supply)
May dispense up to a 90-day supply at a time.
Refills: x 1 year

AND

☐**auto***ject*® 2 *for glass syringe* injection device with instructions for use and travel pouch ***(Free of charge)*** Refills: PRN

(✓) Check for Injection Trng Orders

☐Shared Solutions® to refer/coordinate injection training?
If first dose of medication will be/has been administered by the physician's office, please provide the date. Date:

☐Current **COPAXONE®** Patient – Need Refresher Training Only

Patient Authorization to Use and Disclose Protected Health Information

I authorize each of my health care provider(s) and my health insurer(s) to use and disclose my protected health information ('PHI') related to: my medical condition and treatment, my health insurance and payment/benefits information, the services provided, and my demographic and contact information to Patient Services and Solutions, Inc. (d/b/a Shared Solutions and Shared Solutions Pharmacy (collectively referred to as the Program)) and its affiliates, agents and representatives for the purposes described below.

I understand that the purpose of this Authorization is (i) to enroll me in the Program and contact me by mail, email, text message or by live, autodialed and/or prerecorded messages at the telephone number(s) listed above, or to any future telephone number(s) provided by me (ii) to conduct benefits investigation and coordinate my insurance coverage (iii) to coordinate prescription fulfillment or financial assistance; and/or (iv) for marketing purposes which 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 which may be funded or sent by a Program affiliate and/or (v) for market research purposes which includes contacting me to participate in focus groups, surveys or interviews.

Read and Sign Patient Authorization

While the Program will safeguard my information and only use it for intended purposes, I understand that once my health information is disclosed it may be re-disclosed by the Program and other recipients and no longer be protected by federal privacy law. This authorization will remain in effect until the Shared Solutions program ends. I understand that I may revoke this authorization at any time, in writing sent to Patient Services and Solutions, Inc., Attn: Chief Privacy Officer, P.O. Box 7588, Overland Park, KS 66207, but that this revocation will only apply to my health care provider(s) and health insurer(s) once they receive notification of my revocation and only to the extent that they have not already taken action based on it. I understand that my refusal to sign this authorization does not impact my right to treatment, payment for treatment, insurance enrollment, eligibility for insurance benefits, as these are not conditioned on me signing this authorization.

Patient's Signature:_____ **Date:** _____

If signed by someone other than patient, describe legal authority to do so.

Prescriber Signature Required for Prescription Orders

Statement of Medical Necessity: Primary Diagnosis ICD-10 CM G35 Treatment of Relapsing Forms of MS
I authorize Patient Services and Solutions, Inc. to provide any information on this form to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery to the pharmacy chosen by the named patient.

Prescriber's Signature:

(Dispense as Written) *(Brand Exchange Permissible)* *Date*

NPI #:	Signature stamps not acceptable.	Please attach all prescriptions on Official State Prescription form if mandated by individual state laws.