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 my healthcare providers, pharmacies and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including its third party patient support program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

Read and Sign Patient Authorization

I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, P.O. Box 7588, Overland Park, KS 66207, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

o By checking this box, I certify that I am at least 18 years old and consent to receive promotional or educational messages from Teva and its affiliates and agents by direct mail and email, as well as electronic or telephonic means at the telephone number provided on this form using automated technology and/or prerecorded voice messages, to provide me with information regarding Multiple Sclerosis, Teva products, and programs and to conduct market research. I understand my consent is not a condition of purchase. Additional terms apply: http://www.pssmobileterms.com/.

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.