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

MSLifeLines®

Fax this form to: 1-866-227-3243 | Call us toll free: 1-877-447-3243

STEP 1: Complete Physician Information

Prescriber's Name: _____
Contact Name: _____
Office/Clinic/Institution: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
Prescriber's Email: _____
Tax ID #: _____
State Medical License #: _____
DEA #: _____ NPI #: _____

STEP 2: Complete Patient Information

Patient Name: _____
SS #: _____ DOB: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
Preferred Phone: ☐Home ☐Work ☐Cell
Okay to leave a message at home: ☐ Yes ☐No
Email: _____

STEP 3A & 3B: Patient Authorization

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

PATIENT NAME (please print): _____

PATIENT SIGNATURE (or personal representative): _____ **Date:** _____

Authority/relationship of personal representative: ☐Legal Guardian ☐Power of Attorney

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

STEP 4: Reason for Prescription

Check box(es):

☐ Start
☐ Restart
☐ Refill
☐ Dose change
☐ Delivery method change
☐ Insurance change
☐ Nurse training visit only
☐ MS LifeLines® services (patient has medication)
☐ Titration Clip

Fill out this section if you would like to write a prescription for Rebif

STEP 5A: Device

DEVICE: Device to be used in conjunction with the prefilled syringe delivery method.

☐ **Rebiject II® autoinjector**

Quantity: _____
Directions for use: _____
Refills: _____

Prescriber signature: _____
Date: _____
Prescriber NPI: _____

STEP 5B: Delivery Method

DELIVERY METHOD: (Choose One)

☐ **Rebif® Prefilled Syringe**

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

STEP 5C: Titration

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

Prescriber Signature (Dispense as written): _____
Prescriber Signature (Substitution permitted): _____
Date: _____ **Prescriber NPI:** _____

STEP 5D: Check Below for Ongoing Rx

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

44 mcg (Choose one option below)

Dispense 1 box (12) Refills: _____
44 mcg/0.5 mL subcutaneous 3 times weekly

Dispense 3 boxes (36) Refills: _____
44 mcg/0.5 mL subcutaneous 3 times weekly

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

_____
_____

22 mcg (Choose one option below)

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

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

Prescriber Signature (Dispense as written): _____
Prescriber Signature (Substitution permitted): _____
Date: _____ **Prescriber NPI:** _____

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

MSLifeLines®

Fax this form to: 1-866-227-3243 | Call us toll free: 1-877-447-3243

STEP 5E: Titration Clips

☐ **Titration Clip Multi-Pack** for use with Rebif prefilled syringe only

QTY of packs: _____ 20% and 50% clips included in each pack (6 of each %)

Directions for use:_____

Refills: _____

Pre-filled Rebif Syringe	Rebif mcg dosage delivered using 20% (white) Titration Clip	Rebif mcg dosage delivered using 50% (green) Titration Clip
22 mcg	4.4 mcg	11 mcg
44 mcg	8.8 mcg	22 mcg

Prescriber Signature: _____ **Date:**_____ **Prescriber NPI:** _____

STEP 6: Complete Insurance Information

☐ No insurance ☐ Insurance change ☐ Insurance card/cards attached (front and back)

Primary Insurance: _____
Cardholder:_____
ID #: _____ Group #: _____

Phone #: _____
Does this patient have a separate pharmacy benefit card? ☐ Yes ☐ No

Name of Pharmacy Benefit Manager: _____
ID #: _____ Group #: _____

Is there a pharmacy where you would like MSLL to send this prescription?

☐ Yes _____

STEP 7: Complete and Sign Statement of Medical Necessity

PRIMARY DIAGNOSIS: ICD-10 code G35

I certify the prescribed therapy is medically necessary for the treatment of relapsing forms of multiple sclerosis, and that this information is accurate to the best of my knowledge.
Patient was previously treated with:
_____

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) forward the above prescription by fax or by other mode of delivery to the pharmacy chosen by the above named patient.

Physician's Signature: _____ **Date:** _____

☐ **By checking this box, 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.**

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

If you have any questions regarding MS LifeLines Services, please call 1-877-447-3243.

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 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 and/or to conduct market research activities which includes contacting me to participate in focus groups, surveys or interviews which 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 (e.g., 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.

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 ten 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, One Technology Place, Rockland, MA 02370. 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 3A 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 on this Form (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' patient support 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 "S" via return text message or contacting EMD Serono in writing at EMD Serono & MS LifeLines, One Technology Place, Rockland, MA 02370.

Please check the box listed in Step 3B on Page 1 to authorize your consent.

Rebif®
(interferon beta-1a)
subcutaneous injection

MSLifeLines®

TO BEGIN THE PRESCRIPTION PROCESS FOR REBIF® (INTERFERON BETA-1A) FOLLOW THESE STEPS:

- ☑ Have your patient read the Patient Consent Information and request that the patient **sign the indicated area (3A)** on the Service Request Form
  - o Patient confidentiality is very important to EMD Serono. Signing the consent line (3A) will help to expedite your patient's enrollment in the MS LifeLines® Patient Support Program, which includes determining eligibility for financial assistance programs
- ☑ **Complete the rest of the Service Request Form**
  - o Prescriber signatures are required in the indicated sections to complete the prescription as well as for medical necessity
  - o Incomplete areas may delay the start of treatment
- ☑ Fax to **MS LifeLines at 1-866-227-3243**

The Rebif Prescriptions and Service Request Form can be found on **Rebif.com/HCP** or by requesting one from your Key Account Manager. If you have questions about the form, please call MS LifeLines at 1-877-447-3243.

US/REB/0419/0041a

1 Complete prescriber information

Ensure this information is complete to help expedite enrollment process–NPI # and Tax ID # are critical.

3 Patient signature and acknowledgement for 3A & 3B

Have patient read the consent and authorization and then sign. Have patient read the Marketing Text Message consent and check the box if they agree.

To ensure a quick and efficient enrollment process (including benefits investigation and eligibility check for MS LifeLines Financial Assistance programs), patient must sign 3A (consent and authorization).

3B: Patient opt in for text communications from MS LifeLines and EMD Serono.

5B Delivery method

Prescriber must choose one of the two delivery methods offered.

5D Check for ongoing Rx

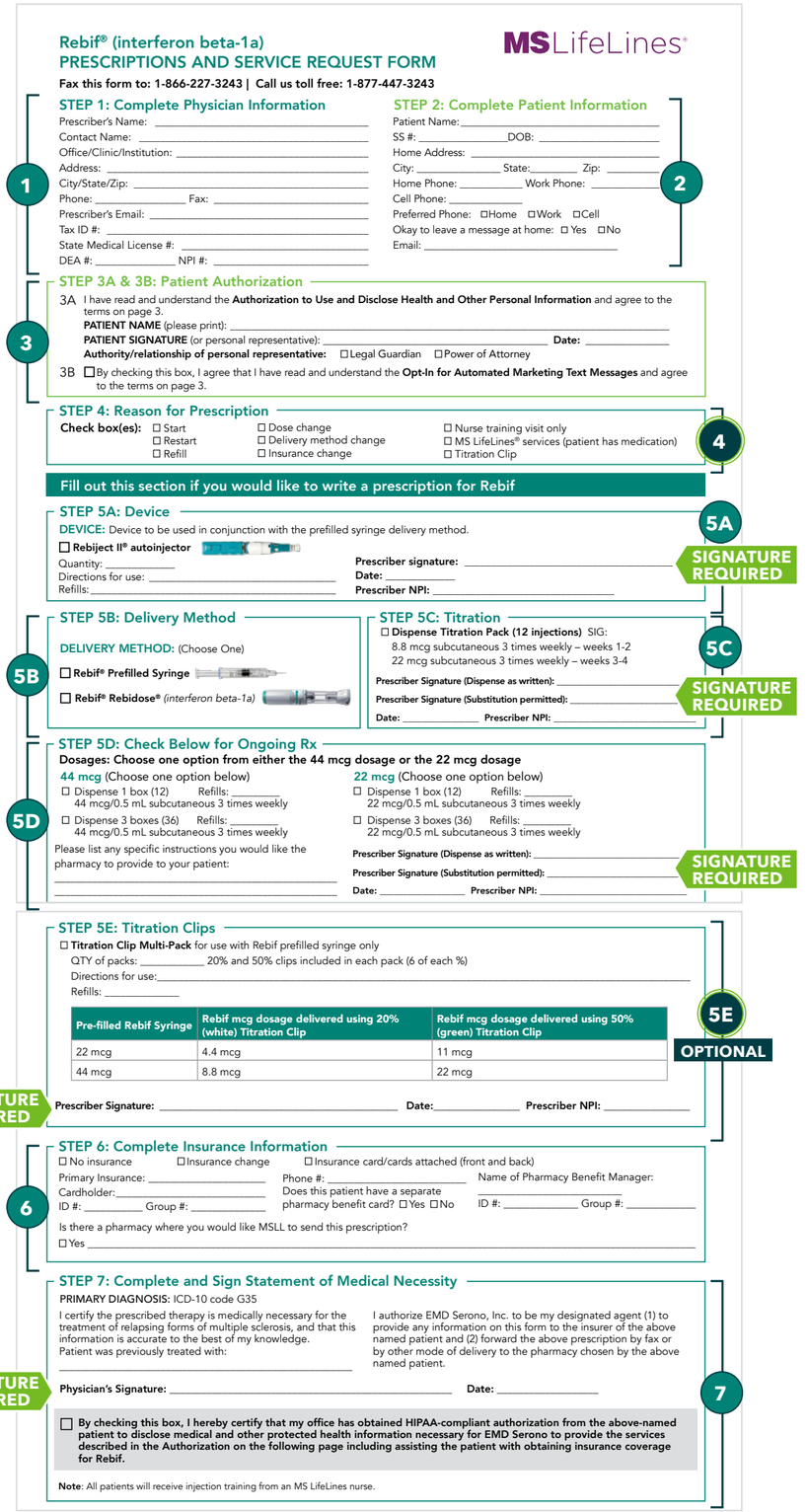
Prescriber to choose ONE option from either the 44-mcg dosage or the 22-mcg dosage. Specific pharmacy instructions may also be included.

Prescriber to sign *either* "Dispense as written" or "Substitution permitted" and include NPI #. **If an ongoing Rx is requested, not completing this step will require additional follow-up that may delay the prescription.**

6 Complete patient's insurance and pharmacy benefit information

Please fax copies of patient's insurance cards (front/back) along with this form. These copies can be supplied in lieu of written information.

Add preferred pharmacy. If it is allowed by insurance, MS LifeLines will forward prescription; if not, MS Lifelines will communicate an alternate pharmacy to process the prescription.



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PRESCRIPTIONS AND SERVICE REQUEST FORM

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STEP 1: Complete Physician Information
Prescriber's Name: _____
Contact Name: _____
Office/Clinic/Institution: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
Prescriber's Email: _____
Tax ID #: _____
State Medical License #: _____
DEA #: _____ NPI #: _____

STEP 2: Complete Patient Information
Patient Name: _____
SS #: _____ DOB: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
Preferred Phone: ☐Home ☐Work ☐Cell
Okay to leave a message at home: ☐Yes ☐No
Email: _____

STEP 3A & 3B: Patient Authorization
3A I have read and understand the **Authorization to Use and Disclose Health and Other Personal Information** and agree to the terms on page 3.
PATIENT NAME (please print): _____
PATIENT SIGNATURE (or personal representative): _____ **Date:** _____
Authority/relationship of personal representative: ☐Legal Guardian ☐Power of Attorney
3B ☐By checking this box, I agree that I have read and understand the **Opt-In for Automated Marketing Text Messages** and agree to the terms on page 3.

STEP 4: Reason for Prescription
Check box(es): ☐Start ☐Restart ☐Refill ☐Dose change ☐Delivery method change ☐Insurance change ☐Nurse training visit only ☐MS LifeLines® services (patient has medication) ☐Titration Clip

Fill out this section if you would like to write a prescription for Rebif

STEP 5A: Device
DEVICE: Device to be used in conjunction with the prefilled syringe delivery method.
☐ **Rebiject II® autoinjector**
Quantity: _____
Directions for use: _____
Refills: _____
Prescriber signature: _____
Date: _____
Prescriber NPI: _____
SIGNATURE REQUIRED

STEP 5B: Delivery Method
DELIVERY METHOD: (Choose One)
☐ **Rebif® Prefilled Syringe**
☐ **Rebif® Rebidose®** *(interferon beta-1a)*

STEP 5C: Titration
☐ **Dispense Titration Pack (12 injections)** SIG:
8.8 mcg subcutaneous 3 times weekly – weeks 1-2
22 mcg subcutaneous 3 times weekly – weeks 3-4
Prescriber Signature (Dispense as written): _____
Prescriber Signature (Substitution permitted): _____
Date: _____ **Prescriber NPI:** _____
SIGNATURE REQUIRED

STEP 5D: Check Below for Ongoing Rx
Dosages: Choose one option from either the 44 mcg dosage or the 22 mcg dosage
44 mcg (Choose one option below)
☐ Dispense 1 box (12) Refills: _____
44 mcg/0.5 mL subcutaneous 3 times weekly
☐ Dispense 3 boxes (36) Refills: _____
44 mcg/0.5 mL subcutaneous 3 times weekly
22 mcg (Choose one option below)
☐ Dispense 1 box (12) Refills: _____
22 mcg/0.5 mL subcutaneous 3 times weekly
☐ Dispense 3 boxes (36) Refills: _____
22 mcg/0.5 mL subcutaneous 3 times weekly
Please list any specific instructions you would like the pharmacy to provide to your patient:
_____
_____
Prescriber Signature (Dispense as written): _____
Prescriber Signature (Substitution permitted): _____
Date: _____ **Prescriber NPI:** _____
SIGNATURE REQUIRED

STEP 5E: Titration Clips
☐ **Titration Clip Multi-Pack** for use with Rebif prefilled syringe only
QTY of packs: _____ 20% and 50% clips included in each pack (6 of each %)
Directions for use: _____
Refills: _____

Pre-filled Rebif Syringe	Rebif mcg dosage delivered using 20% (white) Titration Clip	Rebif mcg dosage delivered using 50% (green) Titration Clip
22 mcg	4.4 mcg	11 mcg
44 mcg	8.8 mcg	22 mcg

OPTIONAL
SIGNATURE REQUIRED
Prescriber Signature: _____ **Date:** _____ **Prescriber NPI:** _____

STEP 6: Complete Insurance Information
☐ No insurance ☐Insurance change ☐Insurance card/cards attached (front and back)
Primary Insurance: _____
Cardholder: _____
ID #: _____ Group #: _____
Phone #: _____
Does this patient have a separate pharmacy benefit card? ☐Yes ☐No
Name of Pharmacy Benefit Manager: _____
ID #: _____ Group #: _____
Is there a pharmacy where you would like MSLL to send this prescription?
☐Yes _____

STEP 7: Complete and Sign Statement of Medical Necessity
PRIMARY DIAGNOSIS: ICD-10 code G35
I certify the prescribed therapy is medically necessary for the treatment of relapsing forms of multiple sclerosis, and that this information is accurate to the best of my knowledge.
Patient was previously treated with:
_____
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) forward the above prescription by fax or by other mode of delivery to the pharmacy chosen by the above named patient.
SIGNATURE REQUIRED
Physician's Signature: _____ **Date:** _____
☐ **By checking this box, 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.**
Note: All patients will receive injection training from an MS LifeLines nurse.

SIGNATURE REQUIRED

A signature, date, and Prescriber NPI are required in the sections of the form that you prescribe for your patient with the exception of step 7 where only signature and date are required.

2 Complete patient's information

Ensure this information is complete to help expedite enrollment process - patient contact information is critical.

4 Prescriber reason for prescription

Prescriber must check the box(es) next to the reason for prescription.

5A Device

Only check the box for a device if the patient delivery method will be Rebif prefilled syringes. If this device is selected, it is required to fill out the prescriber NPI and signature.

5C Titration

For patients that are new to therapy, it is recommended to prescribe a titration pack. Prescriber to check the box for titration pack if necessary.

Prescriber to sign *either* "Dispense as written" or "Substitution permitted" and include NPI #. **If a titration pack is requested, not completing this step will require additional follow-up that may delay the prescription.**

5E Titration clips (optional)

Prescriber to check the box for titration clip multi-pack if needed. Titration clips are for use with Rebif prefilled syringes only, titrating down from existing dose. Quantity of packs, directions for use, and number of refills should also be completed by prescriber. **If filling out this section** prescriber must provide signature.

7 Complete and sign Statement of Medical Necessity

Prescriber to sign statement of medical necessity and check box for HIPAA-compliant authorization (if applicable). **Not completing this step will require additional follow-up that may delay the prescription.**