

Copaxone – glatiramer acetate

Thank you for selecting a Preferred Agent

Member Information

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth Date _____
 Address _____
 City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent

Gender (Circle)

Male Female

AGE: _____

Practitioner Information

Name _____
 Agent / Contact Name _____ Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____
 Phone () - Fax () -
 Email _____ @ _____

**Primary Diagnosis Condition /
 Diagnosis Related – Reason for Request**

- Is the patient ambulatory? **Y / N**
- Type of MS:
 - First clinical episode with MRI features consistent with MS
 - Relapsing-remitting MS
- Is the patient taking any other medications for the treatment of MS? **Y / N**
- If yes, please list the medication(s):

Strength / Dose

Duration of Therapy (Expected)

**Formulary Alternatives
 Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
 Reviewed By: _____
 Forwarded To: _____

**FAX Form to
 877-800-5633**