



CareMed

Pharmaceutical Services

Phone: 516.355.2273

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NeuroCare Prescription Form

OncoCare

ImmunoCare

HemaCare

RheumaCare

HepaCare

Patient Information

Last Name	First Name	SSN	DOB
Home Address	City	State	Zip
Home Phone	Work Phone	Parent/Guardian	
Shipping Address	City	State	Zip
Other Pertinent Information			

Delivery Information

Today's Date:	Date & Time Needed:	Deliver to:
		<input type="checkbox"/> Patient's Home <input type="checkbox"/> MD Office/Clinic <input type="checkbox"/> Patient's Work <input type="checkbox"/> Other: _____

Pharmacy Insurance Information

Primary Insurance:	Rx Bin:
ID Number:	Group Number:
Secondary Insurance:	Rx Bin:
ID Number:	Group Number:

Medications (You may tape Prescription here prior to faxing)

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Avonex®	30 mg	20mg IM QW		
<input type="checkbox"/> Copaxone®	20 mg	20mg SQ QD		
<input type="checkbox"/> Rebif®	<input type="checkbox"/> 22 mg <input type="checkbox"/> 44 mg	Inject Rebif SQ TIW		
<input type="checkbox"/> Rebif Titration Pak®				
<input type="checkbox"/> Betaseron®	0.25 mg	0.25mg SQ QOD		
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Physician Information

Prescriber Name:	DEA:		
License:	Office Contact:		
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Diagnoses Information

<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis, 340.00
<input type="checkbox"/> Patient is NON-AMBULATORY
<input type="checkbox"/> Other _____ ICD9 _____

Special Instructions/Information

PRESCRIBER'S SIGNATURE REQUIRED

MD / NP / PA Signature: _____
