Fax to: 1.866.867.4962	Glatopa® (glatiramer acetate injection) 20mg/mL•40mg/mL	PRESCRIPTION AND SERVICE REQUEST FORM	GlatopaCare®	Phone: 1.855.GLATOPA

Patient Information (Please print) (Please circle preferred phone number)	**Name (First, MI, Last, Suffix):**		**Date of Birth:**		**Gender:** ☐M ☐F	
	Address:				City:	
	State:	ZIP:	Home Phone:	Cell Phone:	Email:	
	Allergies:				Previous MS Therapies:	
	Other Medications:					
Prescriber Information	**Physician's Name:**				**NP/PA** (*if prescriber*):	
	Address:				City:	
	State:	ZIP:	Office Phone:	Cell Phone (if applicable):	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:		Member ID:		Group #:	
	Insurance Co. Phone:					
	Rx Card Name:		Rx ID #:		Rx Group #:	
	Rx BIN:		Rx PCN:		Rx Card Phone:	

(✔) Check for Rx(s) Required

☐ Glatopa® 40 mg/mL prefilled syringes
Inject: 40 mg/mL 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

☐ Glatopa® 20 mg/mL prefilled syringes
Inject: 20 mg/mL 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

(✔) Check for Injection Trng Orders

☐ GlatopaCare® to coordinate initial Glatopa training

☐ Current Glatopa patient – needs refresher training only

(✔) Check for Individual Service Selection

☐ Pharmacy Benefit Investigation
☐ Glatopa Injection Training
☐ Glatopaject Device
☐ Prior Authorization Support
☐ Glatopa Starter Kit (Glatopaject® for glass syringe injection device with Instructions for Use and travel pouch)

Patient Authorization to Use and Disclose Protected Health Information

I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, my employer, and my health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Sandoz, its affiliated companies, business partners, and vendors (together, "Sandoz").

I understand that the purpose of this Authorization is so that Sandoz can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with Glatopa, (ii) coordinate my receipt of, and payment for Glatopa, (iii) facilitate my access to Glatopa, (iv) provide me with information about Glatopa and disease awareness and management programs and education materials, (v) manage the GlatopaCare program, (vi) conduct market research, quality assurance, and other internal business activities.

While Sandoz will safeguard my information and only use it for its intended purposes, I understand that once my health information is disclosed it may be re-disclosed by Sandoz and other recipients and no longer be protected by federal privacy law. This authorization will remain in effect until the GlatopaCare program ends. I understand that I may revoke this authorization at any time by calling 1-855-GLATOPA (1-855-452-8672), but that this revocation will only apply to my healthcare 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, or eligibility for insurance benefits, as these are not conditioned on me signing this authorization.

Read and Sign Patient Authorization

Patient's (or Authorized Representative's) Signature:

_____ **Date:** _____

Prescriber Signature Required for Prescription Orders

Statement of Medical Necessity: Primary Diagnosis ICD-10 CM G35 Treatment of Relapsing Forms of MS
I authorize Sandoz 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) *(Substitution Permissible)* *Date*

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

214774 10/2023