MAVENCLAD® (cladribine) tablets PRESCRIPTIONS AND SERVICE REQUEST FORM

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

STEP 1: 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 preferred number: ☐ Yes ☐ No

Email: ______________________________

List Previous DMDs: ______________________________

Last DMD: ______________ Date of last dose: ______________

List concurrent medications: ______________________________

Allergies: ______________________________

STEP 2A & 2B: Patient Authorization

2A I have read and understand the **Authorization to Use and Disclose Health and Other Personal Information** and agree to the terms on the following page.

PATIENT NAME (please print):

____

PATIENT SIGNATURE (or personal representative):

____

Date: ______________

Authority/relationship of personal representative:

☐ Legal Guardian ☐ Power of Attorney

2B ☐ By checking this box, I agree that I have read and understand the **Opt-in for Marketing Text Messages** and agree to the terms on the following page.

STEP 3: Complete Insurance Information

Please fax front and back copies of insurance cards

☐ No Insurance ☐ Insurance change

☐ Insurance card/cards attached (front and back)

Primary Insurance: ______________________________

Cardholder: ______________________________

ID #: ______________ Group #: ______________

Phone #: ______________________________

Preferred Pharmacy: ______________________________

Does this patient have a separate pharmacy benefit card? ☐ Yes ☐ No

Name of Pharmacy Benefit Manager: ______________________________

ID #: ______________ Group #: ______________

STEP 4: Complete Prescriber Information

Prescriber's Name: ______________________________

Office Contact Name: ______________________________

Office/Clinic/Institution: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________ Fax: ______________

Tax ID #: ______________________________

State Medical License #: ______________________________

UPIN #: ______________________________

NPI #: ______________________________

Prescriber Email Address: ______________________________

STEP 5A & 5B: MAVENCLAD® (cladribine) tablets Prescription Information

Patient Weight: ________kg **OR** ________lbs | **Treatment Course:** ☐ Year 1 ☐ Year 2

Check the row corresponding to the number of tablets to prescribe **in the first cycle (month 1) and again in the second cycle (month 2)**
The weight table below is provided for your reference.

Ready to start therapy? ☐ Yes ☐ No
if not ready, expected start date
____

5A FIRST CYCLE (Month 1): Number of MAVENCLAD (cladribine) 10 mg tablets per cycle

Weight Range: kg (~lb)	Day 1	Day 2	Day 3	Day 4	Day 5	Total # of Tablets Authorized in 1st Cycle (Month 1)
☐ 40 to <50 (88 to <110 lb)	1	1	1	1	0	4
☐ 50 to <60 (110 to <132 lb)	1	1	1	1	1	5
☐ 60 to <70 (132 to <154 lb)	2	1	1	1	1	6
☐ 70 to <80 (154 to <176 lb)	2	2	1	1	1	7
☐ 80 to <90 (176 to <198 lb)	2	2	2	1	1	8
☐ 90 to <100 (198 to <220 lb)	2	2	2	2	1	9
☐ 100 to <110 (220 to <242 lb)	2	2	2	2	2	10
☐ 110 and above (≥242 lb)	2	2	2	2	2	10

No Refill. Instructions for Use: Take by mouth daily at intervals of 24 hours approximately the same time each day per product package instructions.

Prescriber Signature (Dispense as written): ______________________________

Prescriber Signature (Substitution permitted): ______________________________

Date: ______________ *Signature stamps not acceptable*

5B SECOND CYCLE (Month 2): Number of MAVENCLAD (cladribine) 10 mg tablets per cycle

Weight Range: kg (~lb)	Day 1	Day 2	Day 3	Day 4	Day 5	Total # of Tablets Authorized in 2nd Cycle (Month 2)
☐ 40 to <50 (88 to <110 lb)	1	1	1	1	0	4
☐ 50 to <60 (110 to <132 lb)	1	1	1	1	1	5
☐ 60 to <70 (132 to <154 lb)	2	1	1	1	1	6
☐ 70 to <80 (154 to <176 lb)	2	2	1	1	1	7
☐ 80 to <90 (176 to <198 lb)	2	2	1	1	1	7
☐ 90 to <100 (198 to <220 lb)	2	2	2	1	1	8
☐ 100 to <110 (220 to <242 lb)	2	2	2	2	1	9
☐ 110 and above (≥242 lb)	2	2	2	2	2	10

No Refill. Instructions for Use: Take by mouth daily at intervals of 24 hours approximately the same time each day per product package instructions.

Prescriber Signature (Dispense as written): ______________________________

Prescriber Signature (Substitution permitted): ______________________________

Date: ______________ *Signature stamps not acceptable*

STEP 6: 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.

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.

Prescriber'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 Mavenclad.**

Please see accompanying full **Prescribing Information** including **boxed WARNING** and **Medication Guide**.

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 on this form, 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 2A 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 "STOP" 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 2B on Page 1 to authorize your consent.

MS LifeLines is an educational patient support service for people living with MS and their families, and is sponsored by EMD Serono, Inc.