

MULTIPLE SCLEROSIS SPECIALTY CARE PROGRAM

Phone: 844-422-6400 •

Fax: 888-850-4018

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____ Relapse/Remitting Progressive
If Relapse Remitting: Has the patient experienced a first clinical episode? Yes No Attach MRI Results Date: _____
Past Failed Therapies: _____
Does the patient have any contraindication(s) to therapy? No Yes If Yes: _____

If Prior Authorization is Denied: Automatically Draft Appeal for Review Send Preferred Formulary Alternatives

4 INJECTION TRAINING: To Be Administered by Pharmacist Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> AVONEX®	<input type="checkbox"/> 30mcg Prefilled Syringe <input type="checkbox"/> 30mcg Single Dose Vial <input type="checkbox"/> 30mcg Avonex Pen	<input type="checkbox"/> Inject 30mcg IM once a week <input type="checkbox"/> Titration: 7.5mcg weekly (over a 4 week period) until target dose is reached which is 30mcg	1 Kit	
<input type="checkbox"/> BETASERON®	<input type="checkbox"/> 0.3mg Lyophilized Powder	<input type="checkbox"/> Inject 0.25mg (1ml) SC every other day <input type="checkbox"/> Titration: Weeks 1-2: Inject 0.0625mg/0.25ml SC every other day Weeks 3-4: Inject 0.125mg/0.50ml SC every other day Weeks 5-6: Inject 0.1875mg/0.75ml SC every other day Weeks 7 and onward: Inject 0.25mg/1ml SC every other day	1 Kit	
<input type="checkbox"/> COPAXONE®	<input type="checkbox"/> 20mg Prefilled Syringe <input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> Inject 20mg SC daily <input type="checkbox"/> Inject 40mg SC three times per week <input type="checkbox"/> Other _____	1 Kit	
<input type="checkbox"/> EXTAVIA®	<input type="checkbox"/> 0.3mg Lyophilized Powder	<input type="checkbox"/> Inject 0.25mg (1ml) SC every other day <input type="checkbox"/> Titration: Weeks 1-2: 0.0625mg/0.25ml SC every other day Weeks 3-4: 0.125mg/0.50ml SC every other day Weeks 5-6: 0.1875mg/0.75ml SC every other day Weeks 7 and onward: 0.25mg/1ml SC every other day	1 Kit	
<input type="checkbox"/> GILENYA®	<input type="checkbox"/> 0.5mg Capsule	<input type="checkbox"/> Take one capsule by mouth once daily <input type="checkbox"/> Other _____		
<input type="checkbox"/> GLATOPA®	<input type="checkbox"/> 20mg Prefilled Syringe	<input type="checkbox"/> Inject 20mg SC daily	30	
<input type="checkbox"/> REBIF®	<input type="checkbox"/> Titration Pack <input type="checkbox"/> 22mcg Prefilled Syringe <input type="checkbox"/> 44mcg Prefilled Syringe <input type="checkbox"/> Rebidose® 22mcg Autoinjector <input type="checkbox"/> Rebidose® 44mcg Autoinjector	<input type="checkbox"/> Titration Pack Rebidose (six 8.8mcg pre-filled autoinjectors and six 22 mcgpre-filled autoinjectors) <input type="checkbox"/> For 22mcg SC 3 times per week maintenance dose: • Weeks 1 & 2: Inject 4.4mcg 3 times per week • Weeks 3 & 4: Inject 11mcg 3 times per week • Weeks 5 and onward: Inject 22mcg 3 times per week <input type="checkbox"/> For 44mcg SC 3 times per week maintenance dose: • Weeks 1 & 2: Inject 8.8mcg 3 times per week • Weeks 3 & 4: Inject 22mcg 3 times per week • Weeks 5 and onward: Inject 44mcg 3 times per week	1 Kit	
<input type="checkbox"/>				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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