Multiple Sclerosis

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPI #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Aubagio®	☐ 7mg tablet ☐ 14 mg tablet	☐ Take one tablet by mouth once a day ☐ Other	☐ 28 day supply ☐ Other	
Avonex®	☐ 30mcg Vial ☐ 30mcg SYR ☐ 30 mcg PEN	☐ Inject 30 mcg IM once a week ☐ Other	☐ 30 day supply ☐ Other	
Betaseron®	☐ 0.3 mg vial	☐ Inject .25 mg (1ml) SC every other day ☐ Other	☐ 28 day supply	
Botox®	☐ 100U ☐ 200U	☐ Inject _____ units as directed ☐ Other	☐ _____ # of vials	
Copaxone®	☐ 20mg/ml ☐ 40 mg/ml	☐ Inject 20 mg SC daily ☐ Inject 40 mg SC three times a week ☐ Other	☐ ____ day Supply ☐ Other	
dalfampridine	☐ 10mg extended-release tablet	☐ Take one tablet by mouth twice daily every 12 hours ☐ Other	☐ 30 day supply ☐ Other	
Elaprase®	☐ 6mg/3ml	☐ Specified:	☐	
Gilenya®	☐ 0.5mg capsule	☐ Take one capsule by mouth once a day ☐ Other	☐ 30 day supply ☐ Other	
glatiramer acetate injection	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times per week and at least 48 hours apart ☐ Other	☐ _____ pre-filled syringes ☐ Other	
Glatopa®	☐ 20mg/ml prefilled syringe ☐ 40mg/ml prefilled syringe	☐ Inject 20mg/ml (1 syringe) SC once a day ☐ Inject 40mg/ml (1 syringe) SC three times per week and at least 48 hours apart ☐ Other	☐ _____ pre-Filled syringes	

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

v. Q420191

Multiple Sclerosis

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Address: _____ ☐ Female
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Phone Number: _____
Email Address: _____
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Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
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CLINICAL INFORMATION

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Height: _____ ft _____ inches Weight: _____ lbs

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☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Mayzent®	☐ .25mg tablet ☐ 2 mg tablet	☐ Take ____ mg by mouth daily ☐ Other	☐ _____ day supply ☐ Other	
Novantrone	☐ 20mg/10ml ☐ 25mh/12.5ml ☐ 30mg/15ml	☐ Infuse____ mg (12 mg/mL) every three months ☐ Other	☐ 30 day supply ☐ Other	
Rebif®	☐ 22mcg prefilled syringe ☐ 44 mcg prefilled syringe	☐ Inject ____ mcg SC three times a week ☐ Other	☐ 30 day supply ☐ Other	
Rebif® Rebidose	☐ 44mcg/0.5ml prefilled syringe	☐ Inject 44mcg SC three times a week ☐ Other	☐ 30 day supply ☐ Other	
Rebif® Rebidose Titration	☐ 8.8mcg/0.2ml – 22mcg/0.5ml	☐ Titration Schedule: Weeks 1-2: 4.4mcg (0.1ml) SC three times a week Weeks 3-4: 11mcg (0.25ml) SC three times a week Weeks 5+: 22mcg (.5ml) SC three times a week ☐ Titration Schedule: Weeks 1-2: 8.8mcg (0.1ml) SC three times a week Weeks 3-4: 22mcg (0.25ml) SC three times a week Weeks 5+: 44mcg (.5ml) SC three times a week ☐ Other	☐ 30 day supply ☐ Other	
Rebif® Syringe Titration	☐ 8.8mcg/0.2ml – 22mcg/0.5ml	☐ Titration Schedule: Weeks 1-2: 4.4mcg (0.1ml) SC three times a week Weeks 3-4: 11mcg (0.25ml) SC three times a week Week 5+: 22mcg (.5ml) SC three times a week ☐ Titration Schedule: Week 1-2: 8.8mcg (0.1ml) SC three times a week Week 3-4: 22mcg (0.25ml) SC three times a week Week 5+: 44mcg (.5ml) SC three times a week ☐ Other	☐ 30 day supply ☐ Other	
Other				

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

v. Q420191