

## **Multiple Sclerosis**

■ Delivery Need By: Deliver to: □ Patient'		nt's Home 🛛 Physician's Office 🗆 O	ther		
PAT	IENT INFORMATION		1ATION		
Address: City: Phone Number: Email Address:	□ Male □ Female State: Zip: DOB:	Prescriber's Name:	Zip:		
<b>INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT &amp; BACK</b>					
CLINICAL INFORMATION					
Diagnosis:		Has the patient been treated previously for this condition?			
ICD-10 Code:		🗆 Yes 🗆 No			
Height: ft	inches Weight: lbs	Medications Failed:			
Alleraies:		Medications On:			
		Other Notes:			
PRESCRIPTION INFORMATION					
Medication:	Dosage/Strength:	Directions:	Quantity: Refills:		
Aubagio	□ 7mg tablet □ 14 mg tablet	<ul> <li>Take one tablet by mouth once a day</li> <li>Other</li> </ul>	□ 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	u # 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	<ul> <li>Take one tablet by mouth twice daily every 12 hours</li> <li>Other</li> </ul>	□ 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	<ul> <li>Inject 20mg/ml (1 syringe) SC once a day</li> <li>Inject 40mg/ml (1 syringe) SC three times per week and at least 48 hours apart</li> <li>Other</li> </ul>	□ pre- filled syringes □ Other		
Glatopa	□ 20mg/ml prefilled syringe □ 40mg/ml prefilled syringe	<ul> <li>Inject 20mg/ml (1 syringe) SC once a day</li> <li>Inject 40mg/ml (1 syringe) SC three times per week and at least 48 hours apart</li> <li>Other</li> </ul>	□ pre- Filled syringes		
Patient is interested in patient support programs		Ancillary supplies provided for administration			

Physician Signature:

Date:

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## **Multiple Sclerosis**

■ Delivery Need By: Deliver to: □ Patient's Home □ Physician's Office □ Other				
PATI	ENT INFORMATION	PRESCRIBER INFORM	IATION	
Patient Name:          □ Male       Address:          □ Female       City:    State:      Phone Number:        Email Address:        Last Four of Social:    DOB:		Prescriber's Name:		
<b>INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT &amp; BACK</b>				
		INFORMATION		
Diagnosis:		Has the patient been treated previously for this condition?		
ICD-10 Code:		□ Yes □ No		
Height: ft inches Weight: lbs Allergies:		Medications Failed: Medications On: Other Notes:		
	PRESCRIPTIO	N INFORMATION		
Medication: Mayzent	Dosage/Strength:      .25mg tablet     2 mg tablet	Directions:  Take mg by mouth daily Other	Quantity:     Refills:	
Novantrone	□ 20mg/10ml □ 25mh/12.5ml □ 30mg/15ml	□ Infuse mg (12 mg/mL) every three months □ Other	□ Other □ 30 day supply □ Other	
Rebif <sup>®</sup>	<ul> <li>22mcg prefilled syringe</li> <li>44 mcg prefilled syringe</li> </ul>	□ Inject mcg SC three times a week □ Other	□ 30 day supply □ Other	
Rebif <sup>®</sup> Rebidose	□ 44mcg/0.5ml prefilled syringe	□ Inject 44mcg SC three times a week □ Other	□ 30 day supply □ Other	
Rebif <sup>®</sup> Rebidose Titration	□ 8.8mcg/0.2ml - 22mcg/0.5ml	□ Titration Schedule:       □ Titration Schedule:         Weeks 1-2: 4.4mcg       Weeks 1-2: 8.8mcg         (0.1ml) SC three times       (0.1ml) SC three times         a week       weeks 3-4: 11mcg         (0.25ml) SC three       (0.25ml) SC three         times a week       times a week         Weeks 5+: 22mcg       (0.25ml) SC three         (Sml) SC three times       a week         Weeks 5+: 22mcg       Weeks 5+: 44mcg         (.5ml) SC three times       (.5ml) SC three         a week       times a week         Other       times a week	□ 30 day supply □ Other	
Rebif <sup>®</sup> Syringe Titration	□ 8.8mcg/0.2ml - 22mcg/0.5ml	□ Titration Schedule:       □ Titration Schedule:         Weeks 1-2: 4.4mcg       Week 1-2: 8.8mcg         (0.1ml) SC three times       a week         a week       week 3-4: 11mcg         Weeks 3-4: 11mcg       Week 3-4: 22mcg         (0.25ml) SC three       (0.25ml) SC three         times a week       Week 5+: 22mcg         Week 5+: 22mcg       Week 5+: 44mcg         (.5ml) SC three times       a week         a week       a week         Other       Other	□ 30 day supply □ Other	
Other				
Patient is interested in patient support programs		Ancillary supplies provided for administration		

Physician Signature:

Date:

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