

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (____) _____ - _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

<p>Diagnosis (ICD-10): <input type="checkbox"/> G35 Multiple Sclerosis (MS) <input type="checkbox"/> Other: _____</p> <p>MS Subtype: <input type="checkbox"/> Relapsing-remitting <input type="checkbox"/> Secondary Progressive Does the patient have documented relapses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary Progressive <input type="checkbox"/> Clinically isolated syndrome</p>	<p>Number of relapses in past year: _____ Date of last MRI: _____ MRI changes: <input type="checkbox"/> Yes <input type="checkbox"/> No Has pregnancy been excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of test: _____ For Mitoxantrone patients: LVEF <50%? <input type="checkbox"/> Yes <input type="checkbox"/> No Lifetime dose (mg/m²): _____ (Not to exceed cumulative dose >140 mg/m²)</p>	<p>Please list previously tried/failed therapies and reason for discontinuation: _____ _____ _____ _____ _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Gilenya®	<input type="checkbox"/> 0.5 mg capsule	<input type="checkbox"/> Take one capsule (0.5 mg) by mouth once daily with or without food.		
<input type="checkbox"/> Glatiramer Acetate	<input type="checkbox"/> 20 mg Prefilled Syringe	<input type="checkbox"/> Inject 20 mg subQ once daily.		
	<input type="checkbox"/> 40 mg Prefilled Syringe (Note: Products are not interchangeable.)	<input type="checkbox"/> Inject 40 mg subQ three times a week, at least 48 hours apart.		
<input type="checkbox"/> Glatopa®	<input type="checkbox"/> 20 mg Prefilled Syringe	<input type="checkbox"/> Inject 20 mg subQ once daily.		
	<input type="checkbox"/> 40 mg Prefilled Syringe (Note: Products are not interchangeable.)	<input type="checkbox"/> Inject 40 mg subQ three times a week, at least 48 hours apart.		
<input type="checkbox"/> Mitoxantrone	<input type="checkbox"/> 20 mg/10 mL Vial	<input type="checkbox"/> Administer _____ mg (12 mg/m ²) as a short IV infusion every 3 months. <input type="checkbox"/> Other: _____		
	<input type="checkbox"/> 25 mg/12.5 mL Vial			
	<input type="checkbox"/> 30 mg/15 mL Vial			
<input type="checkbox"/> Rebif®	<input type="checkbox"/> Titration Pack	<input type="checkbox"/> Initial Target Dose of 22 mcg three times a week: Week 1&2: Inject 4.4 mcg (0.1 mL) subQ three times a week. Week 3&4: Inject 11 mcg (0.25 mL) subQ three times a week, then maintenance dose. (Note: Only prefilled syringes can be used for this titration dose.)		
	<input type="checkbox"/> 22 mcg	<input type="checkbox"/> Initial Target Dose of 44 mcg three times a week: Week 1&2: Inject 8.8 mcg subQ three times a week. Week 3&4: Inject 22 mcg subQ three times a week, then maintenance dose.		
	<input type="checkbox"/> 44 mcg			
	<input type="checkbox"/> Autoinjector <input type="checkbox"/> PFS		<input type="checkbox"/> Inject 22 mcg subQ three times a week. <input type="checkbox"/> Inject 44 mcg subQ three times a week.	

Deliver to: Patient Office Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution Permitted Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____