



MULTIPLE SCLEROSIS SPECIALTY CARE PROGRAM

PATIENT INFORMATION

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: (_____) _____ - _____
 Email: _____
 DOB: _____ / _____ / _____ Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: (_____) _____ - _____
 Fax: (_____) _____ - _____
 NPI: _____ DEA: _____

STATEMENT OF MEDICAL NECESSITY

Date of Diagnosis: _____ / _____ / _____

Diagnosis/ICD-10 Code: G35 Multiple Sclerosis 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: _____

PRESCRIPTION INFORMATION

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	28	
<input type="checkbox"/> GILENYA®	<input type="checkbox"/> 0.5MG CAPSULE	<input type="checkbox"/> TAKE ONE CAPSULE BY MOUTH ONCE DAILY <input type="checkbox"/> OTHER _____	1 Kit	
<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"/> OTHER MEDICATION				

INJECTION TRAINING Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

PRODUCT DELIVERY Patient's Home Physician's Office Pharmacy to Coordinate

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

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

SIGNATURE: _____ DATE: _____ / _____ / _____

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. **CONFIDENTIALITY NOTICE:** THIS FAX IS INTENDED TO BE DELIVERED ONLY TO THE NAMED ADDRESSEE AND CONTAINS CONFIDENTIAL INFORMATION THAT MAY BE PROTECTED HEALTH INFORMATION UNDER FEDERAL AND STATE LAWS. IF YOU ARE NOT THE NAMED ADDRESSEE, YOU SHOULD NOT DISSEMINATE, DISTRIBUTE OR COPY THIS FAX. PLEASE INFORM THE SENDER IMMEDIATELY IF YOU HAVE RECEIVED THIS DOCUMENT IN ERROR AND THEN DESTROY THIS DOCUMENT IMMEDIATELY.