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
❑ **AVONEX®**	❑ 30MCG PREFILLED SYRINGE ❑ 30MCG SINGLE DOSE VIAL ❑ 30MCG AVONEX PEN	❑ INJECT 30MCG IM ONCE A WEEK ❑ **TITRATION:** 7.5MCG WEEKLY (OVER A 4 WEEK PERIOD) UNTIL TARGET DOSE IS REACHED WHICH IS 30MCG	1 Kit	
❑ **BETASERON®**	❑ 0.3MG LYOPHILIZED POWDER	❑ INJECT 0.25MG (1ML) SC EVERY OTHER DAY ❑ **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	
❑ **COPAXONE®**	❑ 20MG PREFILLED SYRINGE ❑ 40MG PREFILLED SYRINGE	❑ INJECT 20MG SC DAILY ❑ INJECT 40MG SC THREE TIMES PER WEEK ❑ OTHER_____	1 Kit	
❑ **EXTAVIA®**	❑ 0.3MG LYOPHILIZED POWDER	❑ INJECT 0.25MG (1ML) SC EVERY OTHER DAY ❑ **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	
❑ **GILENYA®**	❑ 0.5MG CAPSULE	❑ TAKE ONE CAPSULE BY MOUTH ONCE DAILY ❑ OTHER_____	1 Kit	
❑ **REBIF®**	❑ TITRATION PACK ❑ 22MCG PREFILLED SYRINGE ❑ 44MCG PREFILLED SYRINGE ❑ REBIDOSE® 22MCG AUTOINJECTOR ❑ REBIDOSE® 44MCG AUTOINJECTOR	❑ TITRATION PACK REBIDOSE (SIX 8.8MCG PRE-FILLED AUTOINJECTORS AND SIX 22 MCGPRE-FILLED AUTOINJECTORS) ❑ 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 ❑ 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	
❑ **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: _____ / _____ / _____