

# MULTIPLE SCLEROSIS SPECIALTY CARE PROGRAM

Phone: **888-623-3133** • Fax: **844-673-2245**



## 1 PATIENT INFORMATION:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

## 2 PRESCRIBER INFORMATION:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax I.D.: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## 3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_  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: \_\_\_\_\_

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

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

## 5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

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

### PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

| Medication                          | Dosage & Strength   | Direction   | QTY   | Refills |
|-------------------------------------|---|---|-------|---------|
| <input type="checkbox"/> AVONEX®    | <input type="checkbox"/> 30mcg Prefilled Syringe<br><input type="checkbox"/> 30mcg Single Dose Vial<br><input type="checkbox"/> 30mcg Avonex Pen  | <input type="checkbox"/> Inject 30mcg IM once a week<br><input type="checkbox"/> <b>Titration:</b> 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<br><input type="checkbox"/> <b>Titration:</b> Weeks 1-2: Inject 0.0625mg/0.25ml SC every other day<br>Weeks 3-4: Inject 0.125mg/0.50ml SC every other day<br>Weeks 5-6: Inject 0.1875mg/0.75ml SC every other day<br>Weeks 7 and onward: Inject 0.25mg/1ml SC every other day   | 1 Kit |         |
| <input type="checkbox"/> COPAXONE®  | <input type="checkbox"/> 20mg Prefilled Syringe<br><input type="checkbox"/> 40mg Prefilled Syringe  | <input type="checkbox"/> Inject 20mg SC daily<br><input type="checkbox"/> Inject 40mg SC three times per week<br><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<br><input type="checkbox"/> <b>Titration:</b> Weeks 1-2: 0.0625mg/0.25ml SC every other day<br>Weeks 3-4: 0.125mg/0.50ml SC every other day<br>Weeks 5-6: 0.1875mg/0.75ml SC every other day<br>Weeks 7 and onward: 0.25mg/1ml SC every other day   | 1 Kit |         |
| <input type="checkbox"/> GILENYA®   | <input type="checkbox"/> 0.25mg Capsule<br><input type="checkbox"/> 0.5mg Capsule   | <input type="checkbox"/> (Pediatric Patients) 10 years of age and above weighing <40kg: Take one 0.25mg capsule by mouth once daily with or without food<br><input type="checkbox"/> (Pediatric and Adult Patients) 10 years of age and above weighing >40kg: Take one 0.5mg capsule by mouth once daily with or without food<br><input type="checkbox"/> Other: _____  |       |         |
| <input type="checkbox"/> GLATOPA®   | <input type="checkbox"/> 20mg Prefilled Syringe   | <input type="checkbox"/> Inject 20mg SC daily   | 30    |         |
| <input type="checkbox"/> REBIF®     | <input type="checkbox"/> Titration Pack<br><input type="checkbox"/> 22mcg Prefilled Syringe<br><input type="checkbox"/> 44mcg Prefilled Syringe<br><input type="checkbox"/> Rebidose® 22mcg Autoinjector<br><input type="checkbox"/> Rebidose® 44mcg Autoinjector | <input type="checkbox"/> Titration Pack Rebidose (six 8.8mcg pre-filled autoinjectors and six 22 mcgpre-filled autoinjectors)<br><input type="checkbox"/> For 22mcg SC 3 times per week maintenance dose:<br>• Weeks 1 & 2: Inject 4.4mcg 3 times per week<br>• Weeks 3 & 4: Inject 11mcg 3 times per week<br>• Weeks 5 and onward: Inject 22mcg 3 times per week<br><input type="checkbox"/> For 44mcg SC 3 times per week maintenance dose:<br>• Weeks 1 & 2: Inject 8.8mcg 3 times per week<br>• Weeks 3 & 4: Inject 22mcg 3 times per week<br>• Weeks 5 and onward: Inject 44mcg 3 times per week | 1 Kit |         |
| <input type="checkbox"/>            |   |   |       |         |

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Substitution Permitted**

**Dispense As Written**

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.

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