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Multiple Sclerosis Prescription Referral Form (Form 4B)

Date Medication Needed: _____ Ship To: Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy? _____

1: Patient Information

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

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

2: Prescriber Information

Provider 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

Diagnosis: CM G35 Multiple Sclerosis Other: _____
 Has the patient been previously treated for this condition? Yes No
 Prior failed medication (medication and duration of treatment/reason for d/c): _____
 Patient currently on therapy? Yes No Medication(s): _____
 Will patient be stopping above medication before starting new therapy?
 Yes No Discontinuation Date: _____
 Is prescriber a Neurologist? If no, please include neurology consult if available.
 Diagnosis: _____ Other: _____

Number of relapses in past year: _____
 Last MRI date: _____ Any MRI changes? Yes No
 Injection training completed by:
 Novantrone:
 Is patient's LVEF <50%? Yes No
 What is lifetime (cumulative) Novantrone dose (mg/m2)? _____
 Copy of last CBC with differential: _____
 Is patient pregnant, nursing or planning pregnancy? Yes No N/A
 Serum Creatine _____ Creatinine Clearance _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Avonex®	AVOSTARTGRIP Titration Kit 30mcg Prefilled Syringe #4 30mcg Pen #4	Dose Titration: • Week 1: Inject 7.5mcg IM once weekly • Week 2: Inject 15mcg IM once weekly • Week 3: Inject 22.5mcg IM once weekly • Week 4+: Inject 30mcg IM once weekly ----- Inject 30mcg IM once weekly	4 week supply	0
Betaseron®	0.3mg vial	Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ----- Maintenance Dose: 0.25mg /1ml subcutaneously QOD Other:	4 week supply	0
Copaxone®	20mg Prefiled Syringe 40mg Prefiled Syringe	20mg SQ QD 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week	4 week supply	
Extavia®	0.3mg vial	Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ----- Maintenance Dose: 0.25mg /1ml subcutaneously QOD Other:	4 week supply	0
Glatopa®	20mg Prefiled Syringe	20mg SQ QD	4 week supply	
Gilenya®	0.5mg capsule	Take 0.5mg po QD	4 week supply	
Rebif® Rebif Redidose®	Titration Pack (8.8mcg/22mcg) 22mcg Prefilled Syringe 44mcg Prefilled Syringe	Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) ----- Maintenance: Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) Maintenance: Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) Other:	4 week supply	0

PRIOR AUTHORIZATION APPLICATION TO INSURANCE AND PATIENT SUPPORT PROGRAM ARE AVAILABLE AT PROCARE PHARMACY

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

IMPORTANT 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 intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____