Multiple Sclerosis
Self-Injectable Agents (drugs E-Z)
(Extavia®, Rebif®, Plegridy®)

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

Prescriber + Shipping Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber name: _____
NPI: _____
Address: 1151 Old York Road
Apt/Suite: 200 City: Abington State: PA Zip: 19001
Contact: _____
Phone: 215-957-9250 Alternate: _____
Fax: 215-957-9254
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ _____ Diagnosis Date: _____
Type: ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Secondary-progressive ☐ Primary-progressive ☐ Progressive-relapsing
Hepatic Impairment present: ☐ Yes ☐ No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____
Pre-existing hepatic conditions: ☐ HBV ☐ HCV ☐ _____ TB Test: ☐ Positive ☐ Negative Test date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription

Prescription		Quantity		Refill
§ Avonex®, Betaseron®, Copaxone® are available on the Multiple Sclerosis - Self-Injectable Agents Enrollment Form A-D §				
☐ **Extavia®** (interferon beta-1b)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	☐ 15 x 0.3 mg	Vials	0
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-onward: Inject 0.25 mg (1 mL) subcut every other day.	☐ 15 x 0.3 mg	Vials	0
	☐ Inject 0.25 mg (1 mL) subcut every other day	☐ 15 x 0.3 mg	Vials	_____
☐ **Rebif®** (interferon beta-1a)	☐ Week 1-2: Inject 4.4 mcg (0.1 mL) subcut three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subcut three times per week.	☐ 6 x 8.8 mcg 6 x 22 mcg	PFS	0
	☐ Week 5 and thereafter: Inject 22 mcg subcut three times per week	☐ 12 x 22 mcg	☐ Autoinjectors ☐ PFS	_____
	☐ Week 1-2: Inject 8.8 mcg (0.2 mL) subcut three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subcut three times per week.	☐ 6 x 8.8 mcg 6 x 22 mcg	☐ Autoinjectors ☐ PFS	0
	☐ Week 5 and thereafter: Inject 44 mcg subcut three times per week	☐ 12 x 44 mcg	☐ Autoinjectors ☐ PFS	_____
☐ **Plegridy®** (peginterferon beta-1a)	☐ Inject 63 mcg subcut on day 1; then inject 94 mcg on day 15	☐ 1 x 63 mcg 1 x 94 mcg	☐ Pens ☐ PFS	0
	☐ Inject 125 mcg subcut on day 29 and every two weeks thereafter	☐ 2 x 125 mcg	☐ Pens ☐ PFS	_____

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: _____

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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