meijer specialty pharmacy

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Multiple Sclerosis

Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____

Prescriber Name:		◯ MD ◯ DO ◯ NP ◯ PA	NPI:
Office Contact:	Practice Name / Supervising MD: Abington Neurological Associates		
Address: 1151 Old York Road, Suite 200	City: Abington		
State: PA	Zip: 19001	Phone: 215-957-9250	Fax: 215-957-9254

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	◯ Multiple Sclerosis ◯ Other:		Has patient been previously treated for this condition? Y N	
Prior failed medication (medication and duration of treatment/reason for d/c): ◯				
Patient currently on therapy? ◯ Y ◯ N Medication(s):	Will patient be stopping above medication before starting new therapy? ◯ Y ◯ N		Discontinuation Date: / /	
Is prescriber a Neurologist? If no, please include neurology consult if available	◯ Other:	Number of relapses in past year:	Last MRI date: / /	Any MRI changes? ◯ Y ◯ N
Is patient pregnant, nursing or planning pregnancy? ◯ Y ◯ N ◯ N/A	◯ Serum Creatine:	◯ Creatinine Clearance:		

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
◯ **AVONEX®** ◯ PFS ◯ Pen ◯ Lypholized Pwdr Vial	◯ 30mcg/0.5ml (#4)	◯ Inject 30mcg IM once weekly ◯ Other Regimen:	28 Day Supply	
◯ **BETASERON®**	◯ 0.3mg kit PFS (#14)	◯ **Dose Titration:** Titration kit=35DS Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD Weeks 3-4: Inject 0.125mg/0.50ml SQ QOD Weeks 5-6: Inject 0.1875mg/0.75ml SQ QOD Weeks 7+: Inject 0.25mg/1ml SQ QOD ◯ **Maintenance Dose:** Inject 0.25mg/1ml SQ QOD ◯ Other Regimen:	◯ Titration Dose: 35 Day Supply ◯ Maintenance Dose: 28 Day Supply	
◯ **COPAXONE®** ◯ **GLATIRAMER ACETATE** ◯ **GLATOPA®**	◯ 20mg/ml PFS (#30)	◯ Inject 20mg SQ QD	◯ 30 Day Supply	
	◯ 40mg/ml PFS (#12)	◯ Inject 40mg SQ 3x a week (at least 48 hours apart)	◯ 28 Day Supply	
◯ **DALFAMPRIDINE** (generic Ampyra®)	◯ 10mg tablets (#60)	◯ Take 1 tablet by mouth every 12 hours	30 Day Supply	
◯ **EXTAVIA®**	◯ 0.3mg kit PFS (#15)	◯ **Dose Titration:** Titration kit=49DS, 20 Vials Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD Weeks 3-4: Inject 0.125mg/0.50ml SQ QOD Weeks 5-6: Inject 0.1875mg/0.75ml SQ QOD Weeks 7+: Inject 0.25mg/1ml SQ QOD ◯ **Maintenance Dose:** 0.25mg/1ml SQ QOD ◯ Other Regimen:	◯ Titration Dose: 49 Day Supply ◯ Maintenance Dose: 30 Day Supply	
◯ **GILENYA®**	◯ 0.5mg capsule (#30)	◯ Take 0.5mg by mouth QD	◯ 30 Day Supply ◯ 60 Day Supply ◯ 90 Day Supply	
◯ **REBIF®** ◯ **REBIF® REBIDOSE® Autoinjector**	◯ Titration Pack (8.8mcg/22mcg) (#12) ◯ 22mcg/0.5ml PFS (#12) ◯ 44mcg/0.5ml PFS (#12)	**Dose Titration:** ◯ Inject 8.8mcg SQ 3x a week at weeks 1-2, 22mcg SQ 3x a week at weeks 3-4, and 44mcg SQ 3x a week at weeks 5+ (48 hours apart) ◯ Inject 4.4mcg SQ 3x a week at weeks 1-2, 11mcg SQ 3x a week at weeks 3-4, and 22mcg SQ 3x a week at weeks 5+ (48 hours apart) ◯ **Maintenance:** Inject 22mcg (0.5ml) SQ 3x a week (48 hours apart) ◯ **Maintenance:** Inject 44mcg (0.5ml) SQ 3x a week (48 hours apart) ◯ Other Regimen:	◯ Titration Dose: 28 Day Supply (12 pens or syringes) ◯ Maintenance Dose: 28 Day Supply	
◯ **Other Specialty:**				

Injection Training

◯ Patient received injection training ◯ Prescriber's office to provide injection training ◯ Meijer to coordinate injection training

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature:	Date	Physician Signature:	Date

Substitution Permitted Dispense as Written