

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



Multiple Sclerosis

Prescription/Pharmacy Intake Form

Pharmacy: _____ Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ Ship To: Prescriber's Office Patient's Home Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ Male Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____

Insurance provider (Please include copy of front and back of card): _____

ID #: _____ Policy/Group #: _____ Phone #: _____ Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: Self Other: _____ Prescription Card: Yes No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

Patient is new to therapy Restart Patient is currently on therapy

Start date: _____

Primary Diagnosis Code (ICD-10): _____ Diagnosis: RRMS SPMS PPMS PRMS Date of Diagnosis: _____

Current Weight: _____ Date: _____ Current Therapy: Aubagio Avonex Betaseron Copaxone Extavia Gilenya Glatiramer Acetate Glatopa Lemtrada Mavenclad Mayzent Novatrone Ocrevus Plegridy Rebif Tecfidera Tysabri Vumerity

Concomitant Medications: _____ Other Therapies Tried & Failed (Please List): _____

Other Health Conditions: _____ Allergies: _____

MEDICATIONS

Ampyra 10mg Extended Release Tablets

Directions: _____ Qty: _____ Refills: _____

Aubagio 7mg Tablets 14mg Tablets

Directions: _____ Qty: _____ Refills: _____

Avonex 30mcg Pen Prefilled Syringes Titration Kit

Directions: _____ Qty: _____ Refills: _____

Betaseron Directions: _____ Qty: _____ Refills: _____

Copaxone 20mg 40mg Prefilled Syringes

Directions: _____ Qty: _____ Refills: _____

Dalfampridine 10mg Extended Release Tablets Directions: _____ Qty: _____ Refills: _____

Extavia Directions: _____ Qty: _____ Refills: _____

Gilenya 0.5mg Caps Directions: _____ Qty: _____ Refills: _____

Glatiramer Acetate 20mg/mL Prefilled Syringes 40mg/mL Prefilled Syringes

Directions: _____ Qty: _____ Refills: _____

Glatopa 20mg/mL Prefilled Syringes 40mg/mL Prefilled Syringes

Directions: _____ Qty: _____ Refills: _____

Lemtrada Directions: _____ Qty: _____ Refills: _____

Contact MS One to One at 855-557-2478 or at 855-676-6326 (fax)

Lioresal IT Directions: _____ Qty: _____ Refills: _____

Mavenclad 10mg Tablets Directions: _____ Qty: _____ Refills: _____

Mayzent 30 day starter pack 2mg Tablets

Directions: _____ Qty: _____ Refills: _____

Novatrone 10mg/5mL 20mg/10mL

Other: _____ Directions: _____ Qty: _____ Refills: _____

Ocrevus 300mg/10mL Single-Dose Vial Directions: _____ Qty: _____ Refills: _____

Plegridy 63mcg/94mcg Pen Starter Pack 125mcg Pen Maintenance Pack

63mcg/94mcg Prefilled Syringe Starter Pack 125mcg Prefilled Syringe Maintenance Pack

Directions: _____ Qty: _____ Refills: _____

Rebif Titration Pack Rebidoze 22mcg Rebidoze Autoinjector 44mcg Rebidoze Autoinjector

Titration Pack 22mcg Prefilled Syringes 44mcg Prefilled Syringes

Directions: _____ Qty: _____ Refills: _____

Tecfidera 30 Day Starter Pack 120mg Capsules 240mg Capsules

Directions: _____ Qty: _____ Refills: _____

Tysabri Contact Touch (Biogen Idec) at 1-800-456-2255 or at 1-800-840-1278 (fax)

Vumerity 231mg capsules 30 day starter dose bottle

30 day maintenance dose bottle

Directions: _____ Qty: _____ Refills: _____

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.