



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 Acetat ☐ Glatopa ☐ Lemtrada ☐ Mavenclad ☐ Mayzent ☐ Novatrone ☐ Ocrevus ☐ Plegridy ☐ Rebif ☐ Tecfidera ☐ Tysabri ☐ Vumerity

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

Other Health Conditions: Allergies:

MEDICATIONS

<div><input type="checkbox"/> Ampyra 10mg Extended Release Tablets</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Aubagio</div> <div><input type="checkbox"/> 7mg Tablets <input type="checkbox"/> 14mg Tablets</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Avonex 30mcg</div> <div><input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringes <input type="checkbox"/> Titration Kit</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Betaseron</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Copaxone</div> <div><input type="checkbox"/> 20mg <input type="checkbox"/> 40mg <input type="checkbox"/> Prefilled Syringes</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Dalfampridine 10mg Extended Release Tablets</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Extavia</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Gilenya 0.5mg Caps</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Glatiramer Acetate</div> <div><input type="checkbox"/> 20mg/mL Prefilled Syringes <input type="checkbox"/> 40mg/mL Prefilled Syringes</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Glatopa</div> <div><input type="checkbox"/> 20mg/mL Prefilled Syringes <input type="checkbox"/> 40mg/mL Prefilled Syringes</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Lemtrada</div> <div>Contact MS One to One at 855-557-2478 or at 855-676-6326 (fax)</div> <div><input type="checkbox"/> Lioresal IT</div> <div>Directions: Qty: Refills:</div>	<div><input type="checkbox"/> Mavenclad 10mg Tablets</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Mayzent</div> <div><input type="checkbox"/> 30 day starter pack</div> <div><input type="checkbox"/> 2mg Tablets</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Novatrone</div> <div><input type="checkbox"/> 10mg/5mL <input type="checkbox"/> 20mg/10mL</div> <div><input type="checkbox"/> Other:</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Ocrevus 300mg/10mL Single-Dose Vial</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Plegridy</div> <div><input type="checkbox"/> 63mcg/94mcg Pen Starter Pack <input type="checkbox"/> 125mcg Pen Maintenance Pack</div> <div><input type="checkbox"/> 63mcg/94mcg Prefilled Syringe Starter Pack <input type="checkbox"/> 125mcg Prefilled Syringe Maintenance Pack</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Rebif</div> <div><input type="checkbox"/> Titration Pack Rebidoso <input type="checkbox"/> 22mcg Rebidoso Autoinjector <input type="checkbox"/> 44mcg Rebidoso Autoinjector</div> <div><input type="checkbox"/> Titration Pack <input type="checkbox"/> 22mcg Prefilled Syringes <input type="checkbox"/> 44mcg Prefilled Syringes</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Tecfidera</div> <div><input type="checkbox"/> 30 Day Starter Pack</div> <div><input type="checkbox"/> 120mg Capsules <input type="checkbox"/> 240mg Capsules</div> <div>Directions: Qty: Refills:</div> <div><input type="checkbox"/> Tysabri</div> <div>Contact Touch (Biogen Idec) at 1-800-456-2255 or at 1-800-840-1278 (fax)</div> <div><input type="checkbox"/> Vumerity 231mg capsules</div> <div><input type="checkbox"/> 30 day starter dose bottle</div> <div><input type="checkbox"/> 30 day maintenance dose bottle</div> <div>Directions: Qty: Refills:</div>
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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.