



PATIENT INFORMATION	Patient Name: _____	PRESCRIBER INFORMATION	Prescriber's Name: _____
	Address: _____		State License #: _____ NPI #: _____
	City: _____ State: _____ Zip: _____		DEA #: _____
	Primary Phone: _____ DOB: _____		Group or Hospital: _____
	Alternate Phone: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Address: _____
	Email: _____		City: _____ State: _____ Zip: _____
	Primary Language: _____		Phone: _____ Fax: _____
	Height: _____ Weight: _____		Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL	Need By Date: _____	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other:		
	Date of Diagnosis: _____	<input type="checkbox"/> Clinically Isolated Syndrome	<input type="checkbox"/> Relapsing-Remitting	<input type="checkbox"/> Secondary Progressive
	Diagnosis: G35 Multiple Sclerosis	<input type="checkbox"/> Other (ICD-10 Code): _____	<input type="checkbox"/> Primary Progressive	Number of Relapses Last Year: _____
	Previous Disease-Modifying Therapy: _____			
	Current Medications: _____			
Allergies: _____			Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
PRESCRIPTION INFORMATION	<input type="checkbox"/> Aubagio	<input type="checkbox"/> 7mg <input type="checkbox"/> 14mg	<input type="checkbox"/> Take 1 tab PO daily	<input type="checkbox"/> 30	_____
	<input type="checkbox"/> Avonex PFS <input type="checkbox"/> Avonex Pen	<input type="checkbox"/> 30mcg	<input type="checkbox"/> Titration Dosing (PFS): Week 1: Inject 7.5mcg IM Week 2: Inject 15mcg IM Week 3: Inject 22.5mcg IM Week 4: Start injecting 30mcg IM once a week <input type="checkbox"/> Inject 30mcg IM once a week	<input type="checkbox"/> 1 Kit = 4 PFS <input type="checkbox"/> 1 Kit = 4 Pens	_____
	<input type="checkbox"/> Betaseron	<input type="checkbox"/> 0.3mg	<input type="checkbox"/> Titration Dosing: Weeks 1-2: Inject 0.0625mg (0.25mL) SQ QOD Weeks 3-4: Inject 0.125mg (0.5mL) SQ QOD Weeks 5-6: Inject 0.1875mg (0.75mL) SQ QOD Week 7: Start injecting 0.25mg (1mL) SQ QOD <input type="checkbox"/> Inject 0.25mg (1mL) SQ every other day	<input type="checkbox"/> 1 Kit = 14 Devices	_____
	<input type="checkbox"/> Copaxone PFS <input type="checkbox"/> Glatopa PFS <input type="checkbox"/> Glatiramer acetate PFS	<input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Inject 20mg SQ daily <input type="checkbox"/> Inject 40mg SQ 3 times a week <input type="checkbox"/> Other _____	<input type="checkbox"/> 1 Kit = 30 PFS <input type="checkbox"/> 1 Kit = 12 PFS	_____
	<input type="checkbox"/> Dalfampridine	<input type="checkbox"/> 10mg Tab	<input type="checkbox"/> Take 1 tablet PO twice daily approximately 12 hours apart	<input type="checkbox"/> 60	_____
	<input type="checkbox"/> Extavia	<input type="checkbox"/> 0.3mg	<input type="checkbox"/> Titration Dosing: Weeks 1-2: Inject 0.0625mg (0.25mL) SQ QOD Weeks 3-4: Inject 0.125mg (0.5mL) SQ QOD Weeks 5-6: Inject 0.1875mg (0.75mL) SQ QOD Week 7: Start injecting 0.25mg (1mL) SQ QOD <input type="checkbox"/> Inject 0.25mg (1mL) SQ every other day	<input type="checkbox"/> 1 Kit = 15 devices	_____
	<input type="checkbox"/> Gilenya	<input type="checkbox"/> 0.5mg Cap	<input type="checkbox"/> Take 1 cap PO daily	<input type="checkbox"/> 30	_____
	<input type="checkbox"/> Kesimpta Pen	<input type="checkbox"/> 20mg/0.4 mL	<input type="checkbox"/> Initial Dose: Inject 20mg SQ on day 1, day 8, and day 15, followed by 20mg SQ once monthly starting on day 29 <input type="checkbox"/> Inject 20mg SQ once monthly	<input type="checkbox"/> 3 Pens <input type="checkbox"/> 1 Pen	NA _____

x _____ x DISPENSE AS WRITTEN (Date) Ancillary supplies and kits provided as needed for administration	PHYSICIAN SIGNATURE REQUIRED PRODUCT SUBSTITUTION PERMITTED (Date)
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Date Needed: _____ Medication Start Date: _____

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This prescription is valid only if transmitted by facsimile machine by a licensed provider.



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	Date of Diagnosis: _____	<input type="checkbox"/> Clinically Isolated Syndrome <input type="checkbox"/> Relapsing-Remitting <input type="checkbox"/> Secondary Progressive <input type="checkbox"/> Primary Progressive
	Diagnosis: G35 Multiple Sclerosis	<input type="checkbox"/> Other (ICD-10 Code): _____
	Previous Disease-Modifying Therapy: _____	Number of Relapses Last Year: _____
	Current Medications: _____	
Allergies: _____	Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
PRESCRIPTION INFORMATION	<input type="checkbox"/> Mayzent	CYP2C9 Genotype *1/*1, *1/*2, and *2/*2 <input type="checkbox"/> Titration Pack (5-day)	<input type="checkbox"/> Titration Dosing: 0.25mg PO day 1-2, 0.5mg day 3, 0.75mg day 4, 1.25mg day 5, followed by 2mg daily thereafter	<input type="checkbox"/> 1 Titration Kit	NA
		<input type="checkbox"/> 2mg Tab	<input type="checkbox"/> Take 2mg PO daily	<input type="checkbox"/> 30	_____
	<input type="checkbox"/> Ocrevus	<input type="checkbox"/> 300mg/10mL	<input type="checkbox"/> Titration Dosing: 0.25mg PO day 1-2, 0.5mg day 3, 0.75mg day 4, followed by 1mg daily thereafter	<input type="checkbox"/> 112	_____
			<input type="checkbox"/> 0.25mg Tab	<input type="checkbox"/> Take 1mg PO daily	
	<input type="checkbox"/> Plegridy SQ PFS <input type="checkbox"/> Plegridy SQ Autoinjector	<input type="checkbox"/> Titration Pack <input type="checkbox"/> 125mcg/0.5mL	<input type="checkbox"/> Initial Dose: Infuse 300mg IV on day 1, followed by 300mg IV 2 weeks later	<input type="checkbox"/> 2 SDV	_____
			<input type="checkbox"/> Maintenance Dose: Infuse 600mg IV every 6 months		
	<input type="checkbox"/> Plegridy IM PFS	<input type="checkbox"/> 125mcg/0.5mL	<input type="checkbox"/> Titration Dose: Inject 63mcg SQ on day 1, 94mcg on day 15, 125mcg on day 29 and every 14 days thereafter	<input type="checkbox"/> 1 Titration Kit = 2 Pen/PFS	_____
			<input type="checkbox"/> Inject 125mcg SQ every 14 days	<input type="checkbox"/> 2	_____
	<input type="checkbox"/> Ponvory	<input type="checkbox"/> Titration Pack (14 tablets) <input type="checkbox"/> 20mg Tab	<input type="checkbox"/> Titration Dose: Inject 63mcg IM on day 1, 94mcg on day 15, 125mcg on day 29 and every 14 days thereafter	<input type="checkbox"/> 1 Kit = 2 PFS	_____
			<input type="checkbox"/> Titration Dose: Take 2mg PO day 1-2, 3mg day 3-4, 4mg day 5-6, 5 mg day 7, 6mg day 8, 7mg day 9, 8 mg day 10, 9 mg day 11, and 10 mg day 12-14, followed by 20mg daily thereafter	<input type="checkbox"/> 1 Titration Kit	<input type="checkbox"/> NA
<input type="checkbox"/> Rebif PFS <input type="checkbox"/> Rebif Rebidose Autoinjector	<input type="checkbox"/> Titration Pack	<input type="checkbox"/> Titration to 22mcg dose (PFS only): Weeks 1-2: Inject 4.4mcg SQ 3 times a week Weeks 3-4: Inject 11mcg SQ 3 times a week Week 5: Start injecting 22mcg SQ 3 times a week	<input type="checkbox"/> 1 Titration Kit = six 8.8mcg + six 22mcg syringes or autoinjectors	0	
		<input type="checkbox"/> Titration to 44mcg dose: Weeks 1-2: Inject 8.8mcg SQ 3 times a week Weeks 3-4: Inject 22mcg SQ 3 times a week Week 5: Start injecting 44mcg SQ 3 times a week			
<input type="checkbox"/> Rebif PFS <input type="checkbox"/> Rebif Rebidose Autoinjector	<input type="checkbox"/> 22mcg <input type="checkbox"/> 44mcg	<input type="checkbox"/> Inject 22mcg SQ 3 times a week	<input type="checkbox"/> 12	_____	
		<input type="checkbox"/> Inject 44mcg SQ 3 times a week			
		<input type="checkbox"/> Other _____			

PHYSICIAN SIGNATURE REQUIRED

x _____ (Date) x _____ (Date)
 DISPENSE AS WRITTEN PRODUCT SUBSTITUTION PERMITTED
 Ancillary supplies and kits provided as needed for administration

Date Needed: _____ Medication Start Date: _____

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	Current Medications:	
Allergies: _____	Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
PRESCRIPTION INFORMATION	<input type="checkbox"/> Tecfidera <input type="checkbox"/> Dimethyl Fumarate	<input type="checkbox"/> Starter Kit	<input type="checkbox"/> Titration Dose: Take 120mg PO twice daily for 7 days, then take 240mg twice daily thereafter	<input type="checkbox"/> 1 Starter Kit (60 caps)	
		<input type="checkbox"/> 120mg DR Cap (dispensed in multiples of #14)	<input type="checkbox"/> Take 240mg PO twice daily	<input type="checkbox"/> 60	—
		<input type="checkbox"/> 240mg DR Cap	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	—
	<input type="checkbox"/> Vumerity	231mg DR Cap	<input type="checkbox"/> Titration Dose: Take 231mg PO twice daily for 7 days, then take 462mg twice daily thereafter	<input type="checkbox"/> 106 Caps (titration)	NA
			<input type="checkbox"/> Take 462mg PO twice daily	<input type="checkbox"/> 120	—
			<input type="checkbox"/> Other _____	<input type="checkbox"/> _____	—
	<input type="checkbox"/> Zeposia	<input type="checkbox"/> Titration Pack (7-day)	<input type="checkbox"/> Titration Dose: 0.23mg PO day 1-4, 0.46mg day 5-7, followed by 0.92mg daily thereafter	<input type="checkbox"/> 1 Titration Kit	NA
		<input type="checkbox"/> Titration Pack (37-day)	<input type="checkbox"/> Take 0.92mg PO daily	<input type="checkbox"/> 30	—
		<input type="checkbox"/> 0.92mg Cap			—

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