



Multiple Sclerosis | Neurology Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name: _____ DOB: _____
 SSN: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____ Cell Phone: _____
 Known Allergies: _____
 Height: _____ Weight: _____ lbs. M F
 Emergency Contact: _____
 Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
 Policy Number: _____ Group Number: _____
 Rx Bin: _____ Rx PCN: _____
 Secondary Insurance: _____
 Policy Number: _____ Group Number: _____
 Rx Bin: _____ Rx PCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI#: _____ DEA#: _____ TAX ID: _____
 Address: _____ City, State, Zip: _____
 Office Contact: _____ Phone: _____ Fax: _____

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

Multiple Sclerosis Primary ICD-10: G35 Secondary ICD-10: _____ Date of First Demyelinating Event: _____
 Type: Clinically Isolated Syndrome Relapsing-Remitting Secondary Progressive Progressive-Relapsing
 Patients MRI results are consistent with a Multiple Sclerosis diagnoses Comorbidities: _____
 Other Diagnoses: _____ Primary ICD-10: _____ Secondary ICD-10: _____
 Prior Therapies: _____ Reasons for Discontinuation: _____

MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
<input type="checkbox"/> Avonex®	<input type="checkbox"/> 30 mcg Prefilled Syringe #4 <input type="checkbox"/> 30 mcg Pen #4	<input type="checkbox"/> Inject 30 mcg IM once weekly		
<input type="checkbox"/> Betaseron® <input type="checkbox"/> Extavia®	<input type="checkbox"/> 0.3 mg vial	<input type="checkbox"/> Dose Titration: • Week 1-2: Inject 0.0625 mg/0.25 ml subcutaneously QOD • Week 3-4: Inject 0.125 mg/0.50 ml subcutaneously QOD • Week 5-6: Inject 0.1875 mg/0.75 ml subcutaneously QOD • Week 7+: Inject 0.25 mg/1 ml subcutaneously QOD <input type="checkbox"/> Maintenance Dose: 0.25 mg /1 ml subcutaneously QOD <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Copaxone® (DAW)	<input type="checkbox"/> 20 mg Prefilled Syringe <input type="checkbox"/> 40 mg Prefilled Syringe	<input type="checkbox"/> 20 mg SQ QD <input type="checkbox"/> 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week		
<input type="checkbox"/> Dalfampridine®	<input type="checkbox"/> 10 mg ER tablet	<input type="checkbox"/> 10 mg orally twice daily, approximately 12 hours apart		
<input type="checkbox"/> Dimethyl Fumarate	<input type="checkbox"/> 120 mg DR capsule <input type="checkbox"/> 240 mg DR capsule	<input type="checkbox"/> Initial: 120 mg orally twice a day, for 7 days <input type="checkbox"/> Maintenance: 240 mg orally twice a day, starting at day 8		
<input type="checkbox"/> Gilenya®	<input type="checkbox"/> 0.5 mg capsule	<input type="checkbox"/> Take 0.5mg po QD		
<input type="checkbox"/> Glatiramer Acetate <input type="checkbox"/> WhisperJECT™ (autoinjector)	<input type="checkbox"/> 20 mg Prefilled Syringe <input type="checkbox"/> 40 mg Prefilled Syringe	<input type="checkbox"/> 20 mg SQ QD <input type="checkbox"/> 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week <input type="checkbox"/> Autoinjector - to be used with Glatiramer Acetate injection, prefilled, glass syringe		
<input type="checkbox"/> Glatopa® <input type="checkbox"/> GlatopaJECT™ (autoinjector)	<input type="checkbox"/> 20 mg Prefilled Syringe <input type="checkbox"/> 40 mg Prefilled Syringe	<input type="checkbox"/> 20 mg SQ QD <input type="checkbox"/> 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week <input type="checkbox"/> Autoinjector - to be used with Glatopa injection, prefilled, glass syringe		
<input type="checkbox"/> Kesimpta®	<input type="checkbox"/> 20 mg Sensoready® Pen	<input type="checkbox"/> Initial: 20 mg SQ once weekly for 3 doses (weeks 0, 1, and 2) <input type="checkbox"/> Maintenance: 20 mg SQ once monthly, starting at week 4		
<input type="checkbox"/> Rebif® (prefilled syringe) <input type="checkbox"/> Rebif Rebidose® (pen)	<input type="checkbox"/> Titration Pack (8.8mcg/22mcg) <input type="checkbox"/> 22 mcg <input type="checkbox"/> 44 mcg	<input type="checkbox"/> Inject 8.8 mcg subcutaneously three times a week weeks 1-2, 22 mcg subcutaneously three times a week weeks 3-4, and 44 mcg subcutaneously three times a week weeks 5+ (48 hours apart) <input type="checkbox"/> Maintenance: Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) <input type="checkbox"/> Maintenance: Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Tetrabenazine	<input type="checkbox"/> 12.5 mg tablet <input type="checkbox"/> 25 mg tablet	<input type="checkbox"/> 12.5 mg initial dose once daily orally in the morning, may increase to 12.5 mg twice a day after 1 week (max 100 mg/day) <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Other				

ENROLL in nurse training/manufacture program

DELIVERY INFORMATION

Need by: _____ Deliver to: Patient's home MD Office/ Clinic Other: _____

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: _____ DAW Date: _____

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.

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