Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe ID # 3306986

CareMed SPECIALTY PHARMACY

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
☐**Avonex®**	☐ AVOSTARTGRIP Titration Kit ☐ 30 mcg Prefilled Syringe #4 ☐ 30 mcg Pen #4	☐ **Dose Titration:** • **Week 1** - Inject 7.5 mcg IM once weekly • **Week 2** - Inject 15 mcg IM once weekly • **Week 3** - Inject 22.5 mcg IM once weekly • **Week 4+** - Inject 30 mcg IM once weekly ☐ **Inject** 30 mcg IM once weekly		
☐**Betaseron®** ☐**Extavia®**	☐ 0.3 mg vial	☐ **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 ☐ **Maintenance Dose:** 30.25 mg /1 ml subcutaneously QOD ☐ **Other:**_____		
☐**Copaxone®**	☐ 20 mg Prefiled Syringe ☐ 40 mg Prefiled Syringe	☐ 20 mg SQ QD ☐ 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week		
☐**Dalfampridine®**	☐ 10 mg tablets	☐ 10 mg tablets twice daily, approximately 12 hours apart		
☐**Gilenya®**	☐ 0.5 mg capsule	☐ Take 0.5mg po QD		
☐**Glatiramer Acetate** ☐**WhisperJECT™** (autoinjector)	☐ 20 mg Prefiled Syringe ☐ 40 mg Prefiled Syringe	☐ 20 mg SQ QD ☐ 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week ☐ Autoinjector - to be used with Glatiramer Acetate injection, prefilled, glass syringe		
☐**Lemtrada®**	☐ 12 mg/ 1.2 ml single-use vial	☐ Infuse 12 mg over 2 hours daily for 5 consecutive days, followed by 12 mg daily for 3 consecutive days 12 months later		
☐**Rebif®** (prefilled syringe) ☐**Rebif Rebidose®** (pen)	☐ Titration Pack (8.8mcg/22mcg) ☐ 22 mcg ☐ 44 mcg	☐ 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) ☐ **Maintenance:** Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Maintenance:** Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Other:**_____		
☐**Xenazine®**	☐ 12.5 mg ☐ 25 mg			
☐**Other**				

☐ ENROLL in nurse training/manufacturer 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.

CM-802 1.19