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

☐Central Pharmacy: ______________________

☐Retail/Community 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 ☐Novatrone ☐Ocrevus ☐Plegridy ☐Rebif ☐Tecfidera ☐Tysabri

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

Other Health Conditions: ______________________

Allergies: ______________________

MEDICATIONS

☐**Ampyra** 10mg Extended Release Tablet

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: ______

☐**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**

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

☐**Lioresal IT**

Directions: ______________ Qty: ______ Refills: ______

☐**Novantrone**

☐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 Rebidose ☐22mcg Rebidose Autoinjector ☐44mcg Rebidose 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)

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.

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Drug names are the property of their respective owners.

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