PREMIER PHARMACY SERVICES

Phone: 800-540-4700
Fax: 800-540-3400

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

MULTIPLE SCLEROSIS RX ORDER FORM

☐ **CONTINUATION OF THERAPY** **SHIP TO:** ☐ Patient ☐ Physician All supplies, including syringes, will be dispensed if needed.

PATIENT INFORMATION

Date: _____ DOB: _____ ☐ Male ☐ Female SS#_____

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone: _____ Alternate Phone: _____

Height: _____ Weight: _____ Emergency Contact: _____ Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Insurance: _____ Phone: _____

Policy #: _____ Group #: _____

DIAGNOSIS/ CLINICAL

Allergies: _____ ☐ Multiple Sclerosis (ICD-10 Code: G35)

Meds tried & failed: _____

Current Medications: _____ Other ICD-10 Diagnosis Code: _____

Does MRI show features consistent with a MS diagnosis? ☐ Yes ☐ No Other Disease States:_____

Is the patient's functional status ambulatory? ☐ Yes ☐ No _____

PRESCRIPTIONS

	Dispense	Refills
☐ **AMPYRA** (dalfampridine) Take 10mg PO twice daily	60 tablets	
☐ **AVONEX** (interferon beta-1a) ☐ PFS ☐ SDV ☐ PEN Inject 30 mcg/0.5 mL IM every 7 days	1 box	
☐ **BETASERON** (interferon beta-1b) ☐ **Titrate Starter Pack** • Weeks 1-2: Inject 0.0625 mg (0.25 mL) SC every other day • Weeks 3-4: Inject 0.125 mg (0.5 mL) SC every other day • Weeks 5-6: Inject 0.1875 mg (0.75 mL) SC every other day • Weeks 7+: Inject 0.25 mg (1 mL) SC every other day	1 box	
☐ **Maintenance Dosing** • Inject 1 mL (0.25mg) SC every other day	1 box	
☐ **COPAXONE PFS** (glatiramer acetate) ☐ 20mg: Inject 1 mL (20 mg) SC every day ☐ 40mg: Inject 1 mL (40 mg) SC 3 times a week, at least 48 hrs apart	1 box	
☐ **EXTAVIA** (interferon beta-1b) ☐ **Titrate Starter Pack** • Weeks 1-2: Inject 0.0625 mg (0.25 mL) SC every other day • Weeks 3-4: Inject 0.125 mg (0.5 mL) SC every other day • Weeks 5-6: Inject 0.1875 mg (0.75 mL) SC every other day • Weeks 7+: Inject 0.25 mg (1 mL) SC every other day	1 box	
☐ **Maintenance Dosing** • Inject 0.25mg SC every other day	1 box	
☐ **GLATOPIA PFS** (glatiramer acetate) Inject 20 mg SC once daily	1 box	
☐ **GILENYA** (fingolimod) Take 0.5 mg PO daily	30 capsules	

	Dispense	Refills
☐ **PLEGRIDY TITRATE STARTER PACK** ☐ Starter PFS ☐ Starter PEN • Day 1: Inject 63 mcg (0.5 mL) SC • Day 15: Inject 94 mcg (0.5 mL) SC • Day 29: Inject full dose 125 mcg (0.5 mL) SC	1 pack	
☐ **PLEGRIDY** (peginterferon beta-1a) **MAINTENANCE DOSING** ☐ PFS ☐ Pen ☐ Inject 125 mcg (0.5 mL) SC every 14 days	1 pack	
☐ **REBIF TITRATION PACK** ☐ PFS ☐ Rebidose Autoinjector ☐ 22 mcg Dosing (PFS Only) • Weeks 1-2: Inject 4.4 mcg (=0.1ml) SC TIW • Weeks 3-4: Inject 11 mcg (=0.25ml) SC TIW ☐ 44 mcg Dosing • Weeks 1-2: Inject 8.8 mcg (=0.2ml) SC TIW • Weeks 3-4: Inject 22 mcg (=0.5ml) SC TIW	1 pack	
☐ **REBIF** (interferon beta-1a) **MAINTENANCE DOSING** ☐ Rebif 22mcg Rebidose Autoinjector: Inject 22 mcg SC TIW ☐ Rebif 22 mcg PFS: Inject 22 mcg SC TIW ☐ Rebif 44 mcg Rebidose Autoinjector: Inject 44 mcg SC TIW ☐ Rebif 44 mcg PFS: Inject 44 mcg SC TIW	1 box	
☐ **TECFIDERA** (dimethyl fumarate) ☐ **30-Day Starter Pack:** (120 mg PO BID x7 days #14 capsules + 240 mg PO BID x23 days #46 capsules)	1 pack	
☐ 120 mg capsules (120 mg PO BID x7 days #14 capsules) ☐ **Maintenance Dosing** ☐ 240 mg capsules (240 mg PO BID x30 days #60 capsules)		
☐ OTHER: _____ Sig: _____		

PRESCRIBER INFORMATION

Physician Name (please print): _____ Contact Name: _____

NPI: _____ DEA: _____ Tax ID: _____

Office Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for above patient. In order to expedite the process, please providechart notes and most recent labs.

Physician's Signature: _____ ☐ DAW (Dispense as Written) Date _____/_____/_____