PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

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

MULTIPLE SCLEROSIS ORDER FORM

☐ **CONTINUATION OF THERAPY** **Ship to:** ☐ Patient ☐ Physician All supplies, including syringes and needles, will be dispensed if needed.

Patient Info

Patient First Name: _____ Patient Last Name: _____ DOB: _____

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

SSN: _____ Phone: _____ Alt Phone: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Gender: ☐ Male ☐ Female Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical

Height: _____ Weight: _____

Diagnosis: ☐ G35 Multiple Sclerosis ☐ Other: _____

Does MRI show features consistent with MS diagnosis? ☐ Yes ☐ No

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

Current medications: _____

TRIED AND FAILED HISTORY

Has the patient had a trial of Multiple Sclerosis therapy? ☐ No ☐ Yes, please list: _____ Duration: _____

Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects: _____ ☐ Other: _____

Prescription

Medication	QTY	Refill
☐ **AVONEX** (interferon beta-1a) ☐ PFS ☐ PEN Inject 30mcg/0.5mL IM every 7 days	1 Box	____
☐ **BETASERON** (interferon beta-1b) **Single Use Carton Kit** Weeks 1-2: Inject 0.0625mg (0.25mL) SC every other day Weeks 3-4: Inject 0.125mg (0.5mL) SC every other day Weeks 5-6: Inject 0.1875mg (0.75mL) SC every other day Weeks 7+: Inject 0.25mg (1mL) SC every other day	1 Kit (14 cartons)	1
☐ **BETASERON Maintenance Dosing** Inject 0.25mg (1mL) SC every other day	1 Kit	____
☐ **COPAXONE PFS** (glatiramer acetate) ☐ 20mg: Inject 20mg (1mL) SC every day ☐ 40mg: Inject 40mg (1mL) SC 3 times a week at least 48 hours apart	1 Box	____
☐ **dalfampridine (brand: AMPYRA)** Take 10mg tab PO every 12 hours	60 tabs	____
☐ **dimethyl fumarate (brand: TECFIDERA)** ☐ **30-Day Starter Pack** (120mg cap PO BID x7days + 240mg PO BID x23 days)	1 Pack	
☐ 120mg cap PO BID x7days	14caps	
☐ **Maintenance Dosing** 240mg cap PO BID x30 days	60caps	____
☐ **EXTAVIA** (interferon beta-1b) **Blister Unit Kit** Weeks 1-2: Inject 0.0625mg (0.25mL) SC every other day Weeks 3-4: Inject 0.125mg (0.5mL) SC every other day Weeks 5-6: Inject 0.1875mg (0.75mL) SC every other day Weeks 7+: Inject 0.25mg (1mL) SC every other day	1 Kit (15 units)	1
☐ **EXTAVIA Maintenance Dosing** Inject 0.25mg (1mL) SC every other day	1 Kit	____

Medication	QTY	Refill
☐ **GLATOPA PFS** (glatiramer acetate) ☐ 20mg: Inject 20mg SC every day ☐ 40mg: Inject 40mg SC 3 times a week at least 48 hours apart	1 Box	____
☐ **GILENYA** (fingolimod) Take 0.5mg cap PO every day	30 caps	____
☐ **PLEGRIDY** (peginterferon beta-1a) **Starter Pack** ☐ Starter PFS ☐ Starter PEN Day 1: Inject 63mcg (0.5mL) SC Day 15: Inject 94mcg (0.5mL) SC	1 Box	
☐ **PLEGRIDY Maintenance Dosing** ☐ PFS ☐ PEN Inject 125mcg (0.5mL) SC every 14 days	1 Box	____
☐ **REBIF** (interferon beta-1a) **Titration Pack** ☐ PFS ☐ Rebidose Autoinjector ☐ 22mcg dosing (PFS only) Weeks 1-2: Inject 4.4mcg (0.1mL) SC TIW Weeks 3-4: Inject 11mcg (0.25mL)SC TIW ☐ 44mcg dosing Week 1-2: Inject 8.8mcg (0.2mL) SC TIW Week 3-4: Inject 22mcg (0.5mL) SC TIW	1 Box	
☐ **REBIF Maintenance Dosing** ☐ PFS ☐ Rebidose Autoinjector ☐ Inject 22mcg SC TIW at least 48 hours apart ☐ Inject 44mcg SC TIW at least 48 hours apart	1 Box	____
☐ Other: _____ Sig: _____	_____	_____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ State: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

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

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