

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 Current medications: _____
 Is the patient's functional status ambulatory? Yes No
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	Medication	QTY	Refill
	<input type="checkbox"/> AVONEX (interferon beta-1a) <input type="checkbox"/> PFS <input type="checkbox"/> PEN Inject 30mcg/0.5mL IM every 7 days	1 Box	_____	<input type="checkbox"/> GILENYA (fingolimod) Take 0.5mg cap PO every day	30 caps	_____
<input type="checkbox"/> 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	<input type="checkbox"/> PLEGRIDY (peginterferon beta-1a) Starter Pack <input type="checkbox"/> Starter PFS <input type="checkbox"/> Starter PEN Day 1: Inject 63mcg (0.5mL) SC Day 15: Inject 94mcg (0.5mL) SC	1 Box	_____	
<input type="checkbox"/> BETASERON Maintenance Dosing Inject 0.25mg (1mL) SC every other day	1 Kit	_____	<input type="checkbox"/> PLEGRIDY Maintenance Dosing <input type="checkbox"/> PFS <input type="checkbox"/> PEN Inject 125mcg (0.5mL) SC every 14 days	1 Box	_____	
<input type="checkbox"/> COPAXONE PFS (glatiramer acetate) <input type="checkbox"/> 20mg: Inject 20mg (1mL) SC every day <input type="checkbox"/> 40mg: Inject 40mg (1mL) SC 3 times a week at least 48 hours apart	1 Box	_____	<input type="checkbox"/> REBIF (interferon beta-1a) Titration Pack <input type="checkbox"/> PFS <input type="checkbox"/> Rebidose Autoinjector <input type="checkbox"/> 22mcg dosing (PFS only) Weeks 1-2: Inject 4.4mcg (0.1mL) SC TIW Weeks 3-4: Inject 11mcg (0.25mL) SC TIW <input type="checkbox"/> 44mcg dosing Week 1-2: Inject 8.8mcg (0.2mL) SC TIW Week 3-4: Inject 22mcg (0.5mL) SC TIW	1 Box	_____	
<input type="checkbox"/> dalfampridine (brand: AMPYRA) Take 10mg tab PO every 12 hours	60 tabs	_____	<input type="checkbox"/> REBIF Maintenance Dosing <input type="checkbox"/> PFS <input type="checkbox"/> Rebidose Autoinjector <input type="checkbox"/> Inject 22mcg SC TIW at least 48 hours apart <input type="checkbox"/> Inject 44mcg SC TIW at least 48 hours apart	1 Box	_____	
<input type="checkbox"/> dimethyl fumarate (brand: TECFIDERA) <input type="checkbox"/> 30-Day Starter Pack (120mg cap PO BID x7days + 240mg PO BID x23 days) <input type="checkbox"/> 120mg cap PO BID x7days <input type="checkbox"/> Maintenance Dosing 240mg cap PO BID x30 days	1 Pack 14caps 60caps	_____	<input type="checkbox"/> Other: _____ Sig: _____	_____	_____	
<input type="checkbox"/> Zeposia Starter Kit Dose Titration Regimen Days 1-4: 0.23mg PO QD; Days 5-7: 0.46mg PO QD Days 8 and thereafter: 0.92mg PO QD	1 Kit (37 Caps)	0				
<input type="checkbox"/> Zeposia Maintenance Dosing 1 capsule (0.92mg) PO QD	30 caps	_____				

PRIOR AUTHORIZATION

Prescriber Information

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:** ____/____/____

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