Multiple Sclerosis InjectableAgents (G-Z)

(Glatopa™, Lemtrada®, Rebif®, Plegridy®, Zinbryta™)

Phone: 877.977.9118
Fax: 866.208.4142

Patient Information

Patient name: ______________________ DOB: ____________
Sex: ❑ Female ❑ Male SSN: ___________________________
Language: ___________ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: ____
Apt/Suite: _____ City: ______________ State: _____ Zip: ______
Phone: _________________ Alternate: ________________
Caregiver name: __________________ Relation: ____________
Local pharmacy: ___________________ Phone: ____________
Insurance plan: _______________ Plan ID: _______________

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: ____________________________________
NPI: ____
Address: ____
Apt/Suite: ______ City: __________ State: ______ Zip: ______
Contact: ____
Phone: ___________________ Alternate: _______________
Fax: ____
Email: ____
If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ G35 (Multiple Sclerosis) ❑ ______________________ Diagnosis Date: _______________
Type: ❑ Clinically isolated syndrome ❑ Relapsing-remitting ❑ Secondary-progressive ❑ Primary-progressive ❑ Progressive-relapsing
Hepatic Impairment present: ❑ Yes ❑ No AST: _______ U/L ALT: _______ U/L Bilirubin: ________ mg/dL Lab date: __________
Pre-existing hepatic conditions: ❑ HBV ❑ HCV ❑ ________________ TB Test: ❑ Positive ❑ Negative Test date: __________

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
___________	___________	___________	___________
___________	___________	___________	___________
___________	___________	___________	___________

Comorbidities: ____
Concomitant Medications: _____________________________________
Allergies: ❑ NKDA ❑ Other: ___________________________________

Prescription

Prescription		Quantity		Refill
§ Avonex®, Betaseron®, Copaxone®, Extavia® are available on the Multiple Sclerosis Injectables Enrollment Form A-F §				
❑ **Glatopa™** (glatiramer acetate)	❑ Inject 20 mg subcut once daily	❑ 30 x 20 mg	PFS	_____
❑ **Lemtrada®** (alemtuzumab)	To order Lemtrada®, please see the Genzyme for at : lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf Phone: 855-676-6326 Fax: 855-557-2478			
❑ **Rebif®** (interferon beta-1a)	❑ Week 1-2: Inject 4.4 mcg (0.1 mL) subcut three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subcut three times per week.	❑ 6 x 8.8 mcg 6 x 22 mcg	PFS	0
	❑ Week 5 and thereafter: Inject 22 mcg subcut three times per week	❑ 12 x 22 mcg	❑ Autoinjectors ❑ PFS	_____
	❑ Week 1-2: Inject 8.8 mcg (0.2 mL) subcut three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subcut three times per week.	❑ 6 x 8.8 mcg 6 x 22 mcg	❑ Autoinjectors ❑ PFS	0
	❑ Week 5 and thereafter: Inject 44 mcg subcut three times per week	❑ 12 x 44 mcg	❑ Autoinjectors ❑ PFS	_____
❑ **Plegridy®** (peginterferon beta-1a)	❑ Inject 63 mcg subcut on day 1; then inject 94 mcg on day 15	❑ 1 x 63 mcg 1 x 94 mcg	❑ Pens ❑ PFS	0
	❑ Inject 125 mcg subcut on day 29 and every two weeks thereafter	❑ 2 x 125 mcg	❑ Pens ❑ PFS	_____
❑ **Zinbryta™** (daclizumab)	To order, please see the Zinbryta™ forms at https://www.zinbrytarems.com/			

Injection Training Provided by: ❑ Prescriber's Office ❑ Pharmacy ❑ Other: ____________________

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: ______________

Prescriber's Signature:_____________________________________ Date: ___________

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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