

Multiple Sclerosis Self-Injectable Agents (A-F)



Phone: 877.977.9118
Fax: 866.208.4142

(Avonex®, Betaseron®, Copaxone®, Extavia®)

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

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

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> G35 (Multiple Sclerosis) <input type="checkbox"/> _____		Diagnosis Date: _____	
Type: <input type="checkbox"/> Clinically isolated syndrome <input type="checkbox"/> Relapsing-remitting <input type="checkbox"/> Secondary-progressive <input type="checkbox"/> Primary-progressive <input type="checkbox"/> Progressive-relapsing			
Hepatic Impairment present: <input type="checkbox"/> Yes <input type="checkbox"/> No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____			
Pre-existing hepatic conditions: <input type="checkbox"/> HBV <input type="checkbox"/> HCV <input type="checkbox"/> _____ TB Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Test date: _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Quantity	Refill
<input type="checkbox"/> Avonex® (interferon beta-1a)	<input type="checkbox"/> Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	<input type="checkbox"/> 4 x 30 mcg PFS 0
	<input type="checkbox"/> Inject 30 mcg intramuscularly once weekly	<input type="checkbox"/> 4 x 30 mcg <input type="checkbox"/> Pens <input type="checkbox"/> PFS <input type="checkbox"/> Vials _____
<input type="checkbox"/> Betaseron® (interferon beta-1b)	<input type="checkbox"/> Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	<input type="checkbox"/> 14 x 0.3 mg Vials 0
	<input type="checkbox"/> Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	<input type="checkbox"/> 14 x 0.3 mg Vials 0
	<input type="checkbox"/> Inject 0.25 mg (1 mL) subcut every other day	<input type="checkbox"/> 14 x 0.3 mg Vials _____
<input type="checkbox"/> Copaxone® (glatiramer acetate)	<input type="checkbox"/> Inject 20 mg subcut once daily	<input type="checkbox"/> 30 x 20 mg PFS _____
	<input type="checkbox"/> Inject 40 mg subcut three times per week at least 48 hours apart	<input type="checkbox"/> 12 x 40 mg _____
<input type="checkbox"/> Extavia® (interferon beta-1b)	<input type="checkbox"/> Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	<input type="checkbox"/> 15 x 0.3 mg Vials 0
	<input type="checkbox"/> Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-onward: Inject 0.25 mg (1 mL) subcut every other day.	<input type="checkbox"/> 15 x 0.3 mg Vials 0
	<input type="checkbox"/> Inject 0.25 mg (1 mL) subcut every other day	<input type="checkbox"/> 15 x 0.3 mg Vials _____

§Glatopa™, Plegridy®, Rebif®, Zinbryta™ are available on the Multiple Sclerosis - Self-Injectable Agents Enrollment Form G-Z §

Injection Training Provided by: Prescriber's Office Pharmacy Other: _____

For patients requiring immune globulin therapy, please fill out the respective form: [IVIg](#) or [SCLg](#).

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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 810.768.9178 or by emailing compliance@diplomat.is to obtain instructions as to the proper destruction of the transmitted material. Thank you. 04172017