

Multiple Sclerosis Self-Injectable Agents (drugs G-Z)



Phone: 877.977.9118
Fax: 866.208.4142

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

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

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
§ Avonex®, Betaseron®, Copaxone®, Extavia® are available on the Multiple Sclerosis - Self-Injectable Agents Enrollment Form A-F §		
Glatopa™ (glatiramer acetate)	Inject 20 mg subcut once daily	30 x 20 mg PFS _____
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: _____

Stamp signature not allowed, physician signature required.

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.