

# Multiple Sclerosis Self-Injectable Agents (drugs E-Z)



Phone: 877.977.9118  
Fax: 866.208.4142

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

| Information   | Prescriber + Shipping Information  |
|---|--|
| Patient name: _____ DOB: _____<br>Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____<br>Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in<br>Address: _____<br>Apt/Suite: _____ City: _____ State: _____ Zip: _____<br>Phone: _____ Alternate: _____<br>Caregiver name: _____ Relation: _____<br>Local pharmacy: _____ Phone: _____<br>Insurance plan: _____ Plan ID: _____<br><b>Please fax a copy of front and back of the insurance card(s).</b> | Prescriber name: _____<br>NPI: _____<br>Address: _____<br>Apt/Suite: _____ City: _____ State: _____ Zip: _____<br>Contact: _____<br>Phone: _____ Alternate: _____<br>Fax: _____<br>Email: _____<br>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)  |                                       |                        |                      |
|---|---------------------------------------|------------------------|----------------------|
| <b>Diagnosis:</b> <input type="checkbox"/> G35 (Multiple Sclerosis) <input type="checkbox"/> _____ Diagnosis Date: _____<br>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<br>Hepatic Impairment present: <input type="checkbox"/> Yes <input type="checkbox"/> No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____<br>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: _____<br>Concomitant Medications: _____<br>Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____  |                                       |                        |                      |

| Prescription  | Quantity  | Refill   |
|---|---|--|
| § Avonex®, Betaseron®, Copaxone® are available on the Multiple Sclerosis - Self-Injectable Agents Enrollment Form A-D § |   |  |
| <b>Extavia®</b><br>(interferon beta-1b)   | Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day;<br>Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.<br><br>Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day;<br>Week 7-onward: Inject 0.25 mg (1 mL) subcut every other day.<br><br>Inject 0.25 mg (1 mL) subcut every other day  | 15 x 0.3 mg<br>Vials<br><br>15 x 0.3 mg<br>Vials<br><br>15 x 0.3 mg<br>Vials                     |
|   |   | 0<br><br><br>0<br><br>_____  |
| <b>Rebif®</b><br>(interferon beta-1a)   | Week 1-2: Inject 4.4 mcg (0.1 mL) subcut three times per week;<br>Week 3-4: Inject 11 mcg (0.25 mL) subcut three times per week.<br><br>Week 5 and thereafter: Inject 22 mcg subcut three times per week<br><br>Week 1-2: Inject 8.8 mcg (0.2 mL) subcut three times per week;<br>Week 3-4: Inject 22 mcg (0.5 mL) subcut three times per week.<br><br>Week 5 and thereafter: Inject 44 mcg subcut three times per week | 6 x 8.8 mcg<br>6 x 22 mcg<br><br>12 x 22 mcg<br><br>6 x 8.8 mcg<br>6 x 22 mcg<br><br>12 x 44 mcg |
|   |   | PFS<br>Autoinjectors PFS<br>Autoinjectors PFS<br>Autoinjectors PFS                               |
|   |   | 0<br><br><br>0<br><br>_____  |
| <b>Plegridy®</b><br>(peginterferon beta-1a)   | Inject 63 mcg subcut on day 1; then inject 94 mcg on day 15<br><br>Inject 125 mcg subcut on day 29 and every two weeks thereafter   | 1 x 63 mcg<br>1 x 94 mcg<br><br>2 x 125 mcg  |
|   |   | Pens PFS<br>Pens PFS   |
|   |   | 0<br><br>_____   |
| <b>Zinbryta™</b><br>(daclizumab)  | To order, please see the Zinbryta™ forms at <a href="https://www.zinbrytarems.com/">https://www.zinbrytarems.com/</a>   |  |

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.

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