MULTIPLE SCLEROSIS

Benefit Investigation + Prior Authorization Support

Date ______________________

Ship to:: ☐ Patient ☐ Provider

PATIENT INFORMATION::

Patient Name:		Prescriber:			
Street Address:		NPI:			
City, State, Zip:		Group:			
Phone:		Address:			
Social Security Number:		City, State, ZIP			
Date of Birth:	/ /	Office Phone:		Office Fax:	
Sex:	☐ M ☐ F	Primary Contact:			

MEDICAL INFORMATION::

Diagnosis: Multiple Sclerosis G35._____ Other Diagnosis (ICD-10): ___________________________ Prior Treatment(s):	______ Date of Diagnosis ______ Number of Relapses in past 12 months ______ Date of last MRI; Changes ☐ Yes ☐ No	**Please include (with your referral)** ✓ **Insurance card (copy of front + back)** ✓ **Patient demographics** ✓ **CBC + recent chart notes**

PRESCRIPTION INFORMATION::

☐ Ampyra	☐ 10 mg Tablet	Take one 10 mg tablet twice a day 12 hours apart	☐ 30-day supply (#60) Refills __________
☐ Aubagio	☐ 7 mg Tablet ☐ 14 mg Tablet	☐ Take one 7 mg tablet by mouth once daily ☐ Take one 14 mg tablet by mouth once daily	☐ 28-day supply (#28) Refills __________
☐ Avonex	☐ 30 mcg Pen ☐ 30 mcg Syringe ☐ 30 mcg Vial	☐ Inject 30 mcg intramuscularly once a week ☐ Dose Titration:: • Week 1: Inject 7.5 mcg intramuscularly weekly • Week 2: Inject 15 mcg intramuscularly weekly • Week 3: Inject 22.5 mcg intramuscularly weekly • Week 4+: Inject 30 mcg intramuscularly weekly	☐ 4 week supply (1 kit) Refills __________
☐ Betaseron ☐ Extavia	☐ 0.3 mg Vial & Diluent	☐ Inject 0.25 mg (1 mL) SC every other day ☐ Dose Titration:: • Weeks 1-2: Inject 0.0625 mg/0.25 mL SC every other day • Weeks 3-4: Inject 0.125 mg/0.50 mL SC every other day • Weeks 5-6: Inject 0.1875 mg/0.75 mL SC every other day • Weeks 7+: Inject 0.25 mg/1 mL SC every other day ☐ Other _____________________________________	☐ Betaseron :: 28-days (1 kit/14 vials) ☐ Extavia :: 30-day supply (1 kit/15 vials) Refills __________
☐ Copaxone	☐ 20 mg Syringe	☐ Inject 20 mg SC daily ☐ Other _____________________________________	☐ 30-days (1 kit/30 syringes) Refills __________
	☐ 40 mg Syringe	☐ Inject 40 mg SC three times a week ☐ Other _____________________________________	☐ 28-days (1 kit/12 syringes) Refills __________
☐ Gilenya	☐ 0.5 mg Capsule	Take one 0.5 mg capsule by mouth once daily	☐ 30-day supply (#30) Refills __________
☐ Glatopa	☐ 20 mg Syringe	Inject 20 mg SC once daily	☐ 30-day supply (#30) Refills __________
☐ Novantrone	☐ 10 mg/5 ml Vial ☐ 20 mg/10 ml Vial		Qty __________ Refills __________
☐ Rebif	☐ Titration Pack (8.8 mcg/22 mcg) ☐ 22 mcg PFS ☐ 44 mcg PFS	☐ Dose Titration:: • Weeks 1-2: Inject 8.8 mcg SC three times a week • Weeks 3-4: Inject 22 mcg SC three times a week • Weeks 5+: Inject 44 mcg SC three times a week ☐ Inject 44 mg SC three times a week ☐ Other _____________________________________	☐ 4-week supply (1 kit) Refills __________
☐ Tecfidera	☐ Titration Starter Pack (#14/120mg, #46/240mg) ☐ 240 mg capsules (#60/30 days) ☐ 120 mg capsules (#14/7 days)	☐ Titration Starter Pack: Take 120 mg capsule by mouth twice a day for 7 days, followed by 240 mg capsule by mouth twice a day ☐ Maintenance dose: Take 240mg capsule by mouth twice daily ☐ Other _____________________________________	☐ Titration Starter Pack (30-days) ☐ Maintenance Dose (240 mg) (30-days) Refills __________
☐ Tysabri	☐ 300 mg/15 ml Vial		Qty _______ // Refills _______
☐			Qty _______ // Refills _______

PRESCRIBER SIGNATURE ______________________________ ______________________________ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Phone: 855.257.2584 || Fax: 866.680.3539