

Multiple Sclerosis

PATIENT INFORMATION

Patient Name _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell _____
 DOB _____ SSN _____
 Drug Allergies _____ Male Female
 Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____
 NPI# _____ Tax ID _____
 Practice Name _____
 Address _____ Suite _____
 City _____ State _____ Zip _____
 Office Phone _____ Fax _____
 Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____ Secondary Insurance (if applicable) _____
 Policy # _____ Group _____ Policy # _____ Group _____
 Insurance Phone _____ Insurance Phone _____
 Prescription Drug Coverage: Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ PCN/ID# (if available) _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis: G35 Multiple Sclerosis Other ICD 10 _____ Date Diagnosed: ____/____/____
 New to therapy: Yes No Previous Treatment: _____
 Date of Last MRI: ____/____/____ Number of Relapses in Past Year: _____

DRUG NAME	DOSAGE	DIRECTIONS FOR USE	QTY	REFILLS
<input type="checkbox"/> Ampyra (generic)	<input type="checkbox"/> 10mg Tablet	Take 1 tablet by mouth every 12 hours	30 day supply	
<input type="checkbox"/> Aubagio® Genzyme Limited Distribution	<input type="checkbox"/> 7mg <input type="checkbox"/> 14mg	Take 1 tablet daily	28 day supply	
<input type="checkbox"/> Avonex®	<input type="checkbox"/> Vial <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled syringe	<input type="checkbox"/> Titration: Inject Weekly IM as follows: 7.5mcg Week 1, 15mcg Week 2, 22.5mcg Week 3, 30mcg Week 4 and beyond <input type="checkbox"/> Maintenance: Inject 30mcg IM once a week	28 day supply	
<input type="checkbox"/> Betaseron® Kit		<input type="checkbox"/> Titration: Inject every other day SubQ as follows: 0.0625mg (0.25mL) Weeks 1-2, 0.125mg (0.5mL) Weeks 3-4, 0.1875mg (0.75mL) Weeks 5-6, 0.25mg (1mL) Week 7 and thereafter <input type="checkbox"/> Maintenance: Inject 0.25mg SubQ every other day	28 day supply	
<input type="checkbox"/> Copaxone® PFS	<input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Inject 20mg under the skin daily <input type="checkbox"/> Inject 40mg under the skin 3 times each week	28/30 day supply	
<input type="checkbox"/> Extavia® Kit		<input type="checkbox"/> Titration: Inject every other day SubQ as follows: 0.0625mg (0.25mL) Weeks 1-2, 0.125mg (0.5mL) Weeks 3-4, 0.1875mg (0.75mL) Weeks 5-6, 0.25mg (1mL) Week 7 and thereafter <input type="checkbox"/> Maintenance: Inject 0.25mg SubQ every other day	30 day supply	
<input type="checkbox"/> Gilenya®	0.5mg capsule	Take 1 capsule daily with or without food <input type="checkbox"/> First dose observation needed	28 day supply	
<input type="checkbox"/> Glatopa® PFS	<input type="checkbox"/> 20mg	<input type="checkbox"/> Inject 20mg under the skin daily	30 day supply	
<input type="checkbox"/> Ocrevus®	<input type="checkbox"/> 300mg Vial	<input type="checkbox"/> Induction: Infuse 300mg intravenously at week 0 and week 2 <input type="checkbox"/> Maintenance: Infuse 600mg intravenously every 6 months	2	
<input type="checkbox"/> Rebif® Prefilled Syringe	<input type="checkbox"/> Titration Kit <input type="checkbox"/> 22mcg <input type="checkbox"/> 44mcg	<input type="checkbox"/> Titration to 22mcg: Inject SubQ 3 times per week as follows: 4.4mcg Weeks 1-2, 11mcg Weeks 3-4, 22mcg Week 5 and after <input type="checkbox"/> Inject 22mcg SubQ 3 times per week <input type="checkbox"/> Titration to 44mcg: Inject SubQ 3 times per week as follows: 8.8mcg Weeks 1-2, 22mcg Weeks 3-4, 44mcg Week 5 and after <input type="checkbox"/> Inject 44mcg SubQ 3 times per week	28 day supply	
<input type="checkbox"/> Rebif® Rebiodose	<input type="checkbox"/> Titration Kit <input type="checkbox"/> 22mcg <input type="checkbox"/> 44mcg	<input type="checkbox"/> Titration to 22mcg: Inject SubQ 3 times per week as follows: 4.4mcg Weeks 1-2, 11mcg Weeks 3-4, 22mcg Week 5 and after <input type="checkbox"/> Inject 22mcg SubQ 3 times per week <input type="checkbox"/> Titration to 44mcg: Inject SubQ 3 times per week as follows: 8.8mcg Weeks 1-2, 22mcg Weeks 3-4, 44mcg Week 5 and after <input type="checkbox"/> Inject 44mcg SubQ 3 times per week	28 day supply	
<input type="checkbox"/> Tecfidera® Biogen Limited Distribution	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 120mg <input type="checkbox"/> 240mg	<input type="checkbox"/> Titration: Take 120mg twice daily for 7 days, then 240mg twice daily thereafter <input type="checkbox"/> Maintenance: Take 240mg twice daily	30 day supply	
<input type="checkbox"/> Tysabri®	<input type="checkbox"/> 300mg Vial	Infuse 300mg intravenously over 1 hour every 4 weeks	28 day supply	

Enroll in Manufacturer Program/Nurse Training Patient Signature: _____ Date: ____/____/____

Supplies Needed: Syringes/Needles Swabs Sharps Container Other

Patient has received injection training Physician's office to provide injection training Benevere Rx to coordinate injection training

Deliver to: Patient's home MD's Office 1st dose to MD's Office, remaining refills to patient's home

Statement of Medical Necessity: I certify the prescribed therapy is medically necessary and the rationale for use is for the treatment of relapsing forms of Multiple Sclerosis (ICD-10 G35). I will be supervising the patient's treatment accordingly and all information is accurate to the best of my knowledge. I authorize Benevere as my designated agent and on behalf of my patient to (1) provide any information on this form to the insurer of the above name patient and to (2) forward the above prescription by fax or other mode of delivery to the pharmacy chosen by the above named patient.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.