benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Multiple Sclerosis

PRESCRIBER INFORMATION 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 _____

Policy # _____ Group _____

Insurance Phone _____

Prescription Drug Coverage: Company _____

RXGRP# _____ RXBIN# _____ PCN/ID# *(if available)* _____

Secondary Insurance (if applicable) _____

Policy # _____ Group _____

Insurance Phone _____

Phone _____

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
☐ Ampyra (generic)	☐ 10mg Tablet	Take 1 tablet by mouth every 12 hours	30 day supply	
☐ Aubagio® Genzyme Limited Distribution	☐ 7mg ☐ 14mg	Take 1 tablet daily	28 day supply	
☐ Avonex®	☐ Vial ☐ Pen ☐ Prefilled syringe	☐ Titration: Inject Weekly IM as follows: 7.5mcg Week 1, 15mcg Week 2, 22.5mcg Week 3, 30mcg Week 4 and beyond ☐ Maintenance: Inject 30mcg IM once a week	28 day supply	
☐ Betaseron® Kit ☐ Extavia® Kit		☐ 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 ☐ Maintenance: Inject 0.25mg SubQ every other day	28/30 day supply	
☐ Copaxone® PFS ☐ Glatopa® ☐ Glatiramer Acetate®	☐ 20mg ☐ 40mg	☐ Inject 20mg under the skin daily ☐ Inject 40mg under the skin 3 times each week	28/30 day supply	
☐ Gilenya®	0.5mg capsule	Take 1 capsule daily with or without food ☐ First dose observation needed	28 day supply	
☐ Ocrevus®	☐ 300mg Vial	☐ Induction: Infuse 300mg intravenously at week 0 and week 2 ☐ Maintenance: Infuse 600mg intravenously every 6 months	2	
☐ Rebif® ☐ Prefilled Syringe ☐ Rebidose	☐ Titration Kit ☐ 22mcg ☐ 44mcg	☐ 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 ☐ Inject 22mcg SubQ 3 times per week ☐ 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 ☐ Inject 44mcg SubQ 3 times per week	28 day supply	
☐ Tecfidera® Biogen Limited Distribution	☐ Starter Kit ☐ 120mg ☐ 240mg	☐ Titration: Take 120mg twice daily for 7 days, then 240mg twice daily thereafter ☐ Maintenance: Take 240mg twice daily	30 day supply	
☐ Tysabri®	☐ 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 _____