MS Injectable Agents

Employee Owned Thrifty White PHARMACY Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

patient: _____ ☐ male ☐ female DOB: _____ SS#: _____
(last name, first name)

address: _____
(street, city, state, zip)

primary phone number: _____ ☐ cell alternate phone number: _____ ☐ cell

caregiver: _____ allergies: _____ ☐ NKDA

comorbidities: _____ height: _____ weight: _____ ☐ lbs ☐ kg date: _____

Clincal Information

Primary ICD-10 Code: G35 Secondary ICD-10 Code: _____ Date of first demyelinating event: _____

Type: ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Secondary-progressive ☐ Primary-progressive ☐ Progressive-relapsing

Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):

Prior therapies | **Reason for discontinuation**

Prescription	strength	directions	quantity	refill
☐ Avonex® PFS ☐ Avonex® SDV ☐ Avonex® Pen	30 mcg	☐ Titration dosing (Available only for SDV or for PFS using AVOSTARTGRIP™ Titration Kit) Week1: Inject 7.5 mcg (0.25 mL) IM once weekly; WEEK 2: Inject 15 mcg (0.5 mL) IM once weekly; WEEK 3: Inject 22.5 mcg (0.75 mL) IM once weekly; WEEK 4+: Inject 30 mcg (1 mL) IM once weekly	☐ 1 kit = 4 devices	0
		☐ Inject 30 mcg IM once weekly	☐ 1 kit = 4 devices	
☐ Betaseron® ☐ Extavia®	0.3 mg	☐ Titration dose per package insert: WEEKS 1-2: 0.0625 mg/0.25 mL Sub-Q every other day; WEEKS 3-4: 0.125 mg/0.5 mL Sub-Q every other day; WEEKS 5-6: 0.1875 mg/0.75 mL Sub-Q every other day; WEEK 7+: 0.25 mg/1 mL Sub-Q every other day	☐ 1 kit = 14 vials Betaseron®	0
		☐ 0.25 mg/1 mL Sub-Q every other day	☐ 1 kit=15 vials Extavia®	
☐ Copaxone® PFS	☐ 20 mg	☐ Inject 20 mg Sub-Q daily	☐ 30 PFS	
	☐ 40 mg	☐ Inject 40 mg Sub-Q three times weekly	☐ 12 PFS	
☐ Glatopa™ PFS	☐ 20 mg	☐ Inject 20 mg Sub-Q once daily	☐ 30 PFS	
Lemtrada™	*To order Lemtrada™, please see the Genzyme form at lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf*			
☐ Plegridy™ Starter PFS ☐ Plegridy™ Starter PEN	125 mcg	☐ Inject 63 mcg Sub-Q on day 1, 94 mcg on day 15, then 125 mcg every 14 days thereafter	☐ 1 kit = one 63 mcg + one 94 mcg device	0
☐ Plegridy™ PFS ☐ Plegridy™ PEN		☐ Inject 125 mcg Sub-Q once every 14 days	☐ 1 kit = two 125 mcg devices	
☐ Rebif® PFS Titration Pack ☐ Rebif® Rebidose Titration Pack	☐ **Titration to 22 MCG PFS only dose: Weeks 1-2:** inject 4.4 mcg Sub-Q three times weekly; **Weeks 3-4:** Inject 11 mcg Sub-Q three times weekly; **week 5 and thereafter:** Inject 22 mcg Sub-Q three times weekly		☐ 6 x 8.8 mcg PFS and 6 x 22 mcg PFS	
	☐ **Titration to 44 MCG PFS only dose: Weeks 1-2:** inject 8.8 mcg Sub-Q three times weekly; **Weeks 3-4:** Inject 22 mcg Sub-Q three times weekly; **week 5 and thereafter:** Inject 44 mcg Sub-Q three times weekly		☐ 6 x 8.8 mcg PFS and 6 x 22 mcg PFS ☐ 6 x 8.8 mcg Autoinjectors and 6 x 22 mcg Autoinjectors	
☐ Rebif® PFS	☐ 22 mcg/0.5 mL	☐ Inject 22 mcg Sub-Q three times weekly ☐ Other: _____	☐ 12 x 22 mcg PFS ☐ 12 x 22 mcg Autoinjectors	
☐ Rebif® Rebidose	☐ 44 mcg/0.5 mL	☐ Inject 44 mcg Sub-Q three times weekly ☐ Other: _____	☐ 12 x 44 mcg PFS ☐ 12 x 44 mcg Autoinjectors	

Prescriber + Shipping Information

prescriber (print): _____ office contact: _____

preferred method of contact: ☐ phone ☐ fax ☐ email preferred contact persons email: _____

ship to: ☐ patient ☐ office ☐ alternate _____
(shipping address: street, city, state, zip)

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Thrifty White Specialty Pharmacy 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 Thrifty White Specialty Pharmacy.

Insurance Information: please fax copy of insurance card (front + back)