MS Injectable Agents

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

Patient Information

patient: ______________ (last name, first name) male female DOB: ________ SS#: ______________

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)

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