



**patient information**

patient: \_\_\_\_\_ male  
last name, first name 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: \_\_\_\_\_

**Clinical Information**

**Primary ICD-9 Code: 340 Secondary ICD-9 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  Inject 30 mcg IM once weekly	1 kit = 4 devices  1 kit = 4 devices	0
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  0.25 mg/1 mL Sub-Q every other day	1 kit = 14 vials Betaseron®  1 kit= 15 vials Extavia®	0
Copaxone® PFS	20 mg 40 mg	Inject 20 mg Sub-Q daily Inject 40 mg Sub-Q three times weekly	30 PFS 12 PFS	
Glatopa™ PFS	20 mg	Inject 20 mg Sub-Q once daily	30 PFS	
Lemtrada™	<i>To order Lemtrada™, please see the Genzyme form at <a href="http://lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf">lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf</a></i>			
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		<b>Titration to 22 MCG PFS only dose: Weeks 1-2:</b> inject 4.4 mcg Sub-Q three times weekly; <b>Weeks 3-4:</b> Inject 11 mcg Sub-Q three times weekly; <b>week 5 and thereafter:</b> Inject 22 mcg Sub-Q three times weekly  <b>Titration to 44 MCG PFS only dose: Weeks 1-2:</b> inject 8.8 mcg Sub-Q three times weekly; <b>Weeks 3-4:</b> Inject 22 mcg Sub-Q three times weekly; <b>week 5 and thereafter:</b> 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 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  
(street, suite, city, state, zip) shipping address: \_\_\_\_\_ street city state zip

office address: \_\_\_\_\_

phone: \_\_\_\_\_ fax: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

prescriber's signature: \_\_\_\_\_ date: \_\_\_\_\_

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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

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