MS Injectable Agents

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

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-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	☐ 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 (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)