GREATER PLACER SPECIALTY PHARMACY

3133 PROFESSIONAL DRIVE #17 AUBURN, CA 95603
PHONE: 530-885-8582 | FAX: 530-885-8593 OR 888-696-6055 | WWW.GPRX1.COM

Date: _____

MULTIPLE SCLEROSIS PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
Address: _____ Date of Birth: _____
City, State,Zip: _____ SSN: _____
Phone: _____

Need by Date: _____

Ship to: ☐ Patient Home
☐ Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: ☐ 340 Multiple Sclerosis ○ Remitting-relapse ○ Secondary progressive with relapse ○ Progressing-relapse ☐ Other: _____
Date of Diagnosis/ Years with disease: _____ Try and Fail medications: _____ Patient will stop ☐Yes ☐ No D/C date: _____
Last MRI date: _____ Any MRI change? ○Yes ○No Is patient pregnant? ○ Yes ○No ○ N/A ☐Serum Creatinine: _____ ☐ Creatinine Clearance: _____

PRESCRIPTION INFORMATION

☐**INITIAL PRESCRITION** ☐**PREVIOUSLY DISPENSED**

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
☐ Avonex®	☐30mcg PFS #4 ☐30mcg Pen #4	☐ Inject 30mcg IM once weekly	4wk	
☐ Betaseron® ☐ Extavia®	☐ 0.3mg vial	☐ Initial Dose: Inject 0.0625mg SQ every other day, increase dose by 0.0625mg every 2 weeks ☐ Maintenance: Inject 0.25mg SQ every other day ☐ Other:	4wk	
☐ Copaxone®	☐ 20mg PFS	☐ Inject 20mg SQ once daily	4wk	
☐ Gilenya®	☐ 0.5mg	☐ Take 0.5mg by mouth once daily	4wk	
☐ Rebif®	☐ Titration pack (8.8mcg/22mcg) ☐ 22mcg PFS (Prefill Syring) ☐ 44mcg PFS	☐ Titration dose to 22 mcg: Inject 4.4mcg SQ three times weekly for 2 weeks, followed by 11mcg SQ three times weekly for 2 weeks ☐ Titration dose to 44 mcg: Inject 8.8mcg SQ three times weekly for 2 weeks, followed by 22mcg SQ three times weekly for 2 weeks ☐ Maintenance 22mcg: Inject 22mcg SQ three times weekly ☐ Maintenance 44mcg: Inject 44mcg SQ three times weekly	4wk	

☐ Other medication:

NOTES:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Greater Placer Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ ☐**Do not substitute**

Patient Support Programs:

By signing below, I authorize Greater Placer Pharmacy to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____