Multiple Sclerosis
Self-Injectable Agents (A-D)

Phone: 877.977.9118
Fax: 866.208.4142

(Avonex®, Betaseron®, Copaxone®)

Information

Patient name: ______________________ DOB: ____________
Sex: ❑ Female ❑ Male SSN: ____________________________
Language: ___________ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: ____
Apt/Suite: _____ City: _______________ State: _____ Zip: ______
Phone: __________________ Alternate: ________________
Caregiver name: __________________ Relation: ____________
Local pharmacy: ___________________ Phone: ____________
Insurance plan: ________________ Plan ID: _______________
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: ______________________________________
NPI: ____
Address: ____
Apt/Suite: ______ City: ___________ State: _______ Zip: _______
Contact: ____
Phone: ___________________ Alternate: _________________
Fax: ____
Email: ____
If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ G35 (Multiple Sclerosis) ❑ ______________________ Diagnosis Date: ____________
Type: ❑ Clinically isolated syndrome ❑ Relapsing-remitting ❑ Secondary-progressive ❑ Primary-progressive ❑ Progressive-relapsing
Hepatic Impairment present: ❑ Yes ❑ No AST: ________ U/L ALT: ________ U/L Bilirubin: _________ mg/dL Lab date: ___________
Pre-existing hepatic conditions: ❑ HBV ❑ HCV ❑ ____________________ TB Test: ❑ Positive ❑ Negative Test date: ___________

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

Comorbidities: ____
Concomitant Medications: _____________________________________
Allergies: ❑ NKDA ❑ Other: ___________________________________

Prescription

Prescription		Quantity		Refill
❑ **Avonex®** (interferon beta-1a)	❑ Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	❑ 4 x 30 mcg	PFS	0
	❑ Inject 30 mcg intramuscularly once weekly	❑ 4 x 30 mcg	❑ Pens ❑ PFS ❑ Vials	_____
❑ **Betaseron®** (interferon beta-1b)	❑ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	❑ 14 x 0.3 mg	Vials	0
	❑ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	❑ 14 x 0.3 mg	Vials	0
	❑ Inject 0.25 mg (1 mL) subcut every other day	❑ 14 x 0.3 mg	Vials	_____
Copaxone® (glatiramer acetate)	❑ Inject 20 mg subcut once daily ❑ Inject 40 mg subcut three times per week at least 48 hours apart	❑ 30 x 20 mg ❑ 12 x 40 mg	PFS	_____
Glatiramer Acetate	Inject 20 mg subcut once daily Inject 40 mg subcut three times per week at least 48 hours apart	30 x 20 mg 12 x 40 mg	PFS	_____
WhisperJECT™	Autoinjector for use with Glatiramer Acetate (manufacturer limit of one per year)	1 unit	Delivery Device	0
Glatopa™ (glatiramer acetate)	Inject 20 mg subcut once daily	30 x 20 mg	PFS	_____

§Extavia®, Plegridy®, Rebif®, Zinbryta™ are available on the Multiple Sclerosis - Self-Injectable Agents Enrollment Form E-Z §

Injection Training Provided by: ❑ Prescriber's Office ❑ Pharmacy ❑ Other: ______________________

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _______________

Stamp signature not allowed, physician signature required.

Prescriber's Signature:____ Date: ____________

I authorize Diplomat Pharmacy, Inc. 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 Diplomat Pharmacy, Inc.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure underapplicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying thisinformation. If you received this communication in error, please notify the sender immediately by calling 810.768.9178 or by emailing compliance@diplomat.is to obtain instructions as to the proper destruction of the transmitted material. Thank you. 11082017

Copyright © 2017 by Diplomat Pharmacy Inc. All rights reserved. Diplomat is a registered trademark of Diplomat Pharmacy Inc.