MULTIPLE SCLEROSIS PRESCRIPTION FORM

TruCare PHARMACY

Phone: (844) 446-0808 | Fax: (844) 446-0809

Ship To: ☐ Patient ☐ Physician ☐ Pick-Up (store location)

Injection training: ☐ Please complete by pharmacy staff ☐ Completed by physician office staff ☐ Completed by home nurse/manuf program	*Manufacturer care kit:* ☐ Provide to patient ☐ Provided by MD office ☐ Please do not provide	*Manufacturer program enrollment:* ☐ Please complete at pharmacy ☐ Completed by physician office staff ☐ Please do not enroll

Patient Name (Required):	DOB (Required):	Physician Name:	Specialty:
Home Phone:	Cell Phone:	LIC#: DEA #:	NPI#:
Address:		Practice Name/Hospital:	
Emergency Contact Name/Phone #:		Address:	
Patient Soc. Sec #:	Allergies: ☐ NKA	City: State:	Zip:
Height:	Sex: ☐ M ☐ F Weight: ☐ lbs. ☐ Kg	Physician's Phone:	Physician's Fax:

INSURANCE INFORMATION | Please Complete or Attach Copies (front and back) of All Insurance Cards

Primary Ins:	Secondary Ins:	Rx Card (PBM):	Card Holder First Name:
City: State:	City: State:	PBM BIN:	Last Name:
Plan #:	Plan #:	City: State:	Employer:
Group #:	Group #:	Group #:	ID#:
Phone:	Phone:	Phone:	Group #:

DIAGNOSIS INFORMATION | Please FAX clinical notes, Labs, Tests,with the prescription to expedite the Prior Authorization

Primary diagnosis: _____ Prior treatment (include name and date of prior treatment): _____

Current treatment: _____ Name and date of initiation: _____

Number of replases in past year: _____ Last MRI date: _____ ☐ Pregnant or planning pregnancy Serum Creatinine: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG	QTY	REFILLS
☐ **AVONEX**	30mcg ☐ prefilled syringe #4 ☐ pen #4	☐ Inject IM once weekly	☐ 28 days supply	
☐ **BETASERON**	☐ 0.3mg vial	☐ Dose titration: weeks 1-2 inject 0.0625 mg/0.25 ml SQ QOD: weeks 3-4 inject 0.125mg/0.5ml SQ QOD; weeks 5-6 inject 0.187 mg/0.75 ml SQ QOD: weeks 7+ inject 0.25 mg/1 ml SQ QOD ☐ Maintenance dose: 0.25 mg/1 ml SQ QOD	☐ 28 days supply	
☐ **COPAXONE**	☐20mg/mL ☐40mg/mL	☐ 20mg/ml SQ once daily ☐ 40mg/ml SQ three times per week at least 48 hours apart	☐ 28 days supply	
☐ **EXTAVIA**	☐ 0.3mg vial	☐ Dose titration: weeks 1-2 inject 0.0625 mg/0.25 ml SQ QOD: weeks 3-4 inject 0.125mg/0.5ml SQ QOD; weeks 5-6 inject 0.187 mg/0.75 ml SQ QOD: weeks 7+ inject 0.25 mg/1 ml SQ QOD ☐ Maintenance dose: 0.25 mg/1 ml SQ QOD	☐ 28 days supply	
☐ **GILENYA**	☐ 0.5mg capsule	☐ Take 0.5mg capsule PO QD	☐ 28 days supply	
☐ **REBIF** ☐ **Rebif Redidose**	☐ Titration Pack (8.8mcg/22mcg) ☐ 22mcg prefilled syringes ☐ 44mcg prefilled syringes	☐ Dose titration: weeks 1-2: 8.8mcg SQ three times a week; weeks 3-4: 22mcg SQ three times a week; weeks 5+: 44 mcg SQ three times a week ☐ Maintenance inject 22 mcg/0.5ml SQ three times a week ☐ Maintenance inject 44 mcg/0.5ml SQ three times a week	☐ 28 days supply	
☐ **IVIG**	SIG: _____ ☐ Home infusion (will fax "home infusion protocol" to be signed by MD) ☐ MD's Office Infusion		☐ 28 days supply	
☐ **Other**				

# of Medications Prescribed: _____

Physician's Signature: _____ ☐ **DAW (Dispense as Written)** **Date:** _____

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescribers are reminded patients may choose any pharmacy of their choice. Pursuant to OH/MO/VT law, only 1 medication is permitted per order form. Please use new form for additional items. tcv12516