ASP CARES

Multiple Sclerosis Prescription Form

Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

MAIN POINT OF CONTACT
Name:_____
Phone:_____

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____
Home Address:_____ City:_____ State:_____ Zip Code:_____
DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.
Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____
ID#:_____ RxBin:_____ ID#:_____ RxBin:_____
RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____
Secondary Diagnosis:_____ ICD10 Code:_____
Previous Treatment:_____ AST:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Strength	Directions	QTY	Refill
☐ **Avonex**	☐ 30 mcg PFS ☐ 30 mcg SDV ☐ 30mcg pen (single dose)	Inject 30 mcg intramuscularly once a week.	☐ 28-day supply (1 kit) ☐ 84-day supply (3 kits)	
☐ **Betaseron**	0.3 mg	☐ Inject 0.25 mg (1mL) subcutaneously every other day ☐ Other:_____ ☐ Dose Titration: Week 1-2: Inject 0.0625 mg/0.25 ml sub-Q QOD Week 3-4: Inject 0.125 mg/0.50 ml sub-Q QOD Week 5-6: Inject 0.1875 mg/0.75 ml sub-Q QOD Week 7+: Inject 0.25 mg/1 ml sub-Q QOD	☐ 28-day supply (1 kit of 14 vials) ☐ 84-day supply (3 kits of 14 vials)	
☐ **Copaxone**	☐ 20 mg prefilled syringe	Inject 20 mg subcutaneously daily	☐30-day supply (1 kit) ☐90-day supply (3 kits)	
	☐ 40 mg prefilled syringe	Inject 40 mg subcutaneously daily	☐28-day supply (12 syringes) ☐84-day supply (36 syringes)	
☐ **Extavia**	0.3 mg	☐ Inject 0.25 mg (1mL) subcutaneously every other day ☐ Other:_____ ☐ Dose Titration: Week 1-2: Inject 0.0625 mg/0.25 ml sub-Q QOD Week 3-4: Inject 0.125 mg/0.50 ml sub-Q QOD Week 5-6: Inject 0.1875 mg/0.75 ml sub-Q QOD Week 7+: Inject 0.25 mg/1 ml sub-Q QOD	☐30-day supply (1 kit) ☐90-day supply (3 kits)	
☐ **Gilenya**	0.5 mg	Take one capsule by mouth once daily	☐30-day supply (1 bottle) ☐90-day supply (3 bottles)	
☐ **Glatopa**	20 mg prefilled syringe	Inject 20 mg subcutaneously daily	☐30-day supply (1 kit) ☐90-day supply (3 kits)	
☐ **Rebif**	☐Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) ☐rebidos Titration Pack (six 8.8 mcg prefilled autoinjectors & six 22 mcg prefilled autoinjectors	Weeks 1-2: Inject 8.8 mcg subcutaneously three times a week Weeks 3-4: Inject 22 mcg subcutaneously three times a week	28-day supply (1 kit)	
	☐ 22 mcg prefilled syringe ☐ 44 mcg prefilled syringe ☐ Rebidose 22 mcg prefilled autoinjector ☐ Rebidose 44 mcg prefilled autoinjector	☐ Inject 44 mcg subcutaneously three times a week ☐ Other:_____	☐28-day supply (1 kit) ☐84-day supply (3 kits)	
☐ **Tysabri**				

Allergies:

Notes:

Prescriber Name:_____ NPI#:_____
Address:_____ City:_____ State:____ Zip Code:_____
Phone:_____ Fax:_____

***Prescriber Signature:_____ Date:_____**

Please fax completed form to 1 (888) 294-9434