



SPECIALTY PHARMACY

INJECTABLE/INFUSION NEUROLOGY

Lake Mary, FL toll free

toll free fax

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis Code: G35 Multiple Sclerosis Other _____
 Relapsing Remitting Primary Progressive Secondary Progressive Progressive Relapsing
 First clinical episode of MS; if yes, does patient have MRI features consistent with MS? Yes No

Drug Allergies: _____
 History:

- Has the patient been previously treated for this condition? No Yes Medication failed _____
- Is the patient currently on therapy? No Yes Medication failed _____
- Will patient stop taking current therapy before starting new therapy? Yes No
- How long will the patient wait before starting the new therapy? _____
- Are there other medications patient is currently taking? Please list: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Avonex*	30mcg <input type="checkbox"/> PFS <input type="checkbox"/> PEN	<input type="checkbox"/> Inject 30mcg intramuscularly once weekly <input type="checkbox"/> Other: _____	28-day supply	_____
<input type="checkbox"/> Betaseron*	0.3mg Vial	<input type="checkbox"/> Dose Titration: Week 1-2: Inject 0.0625mg (0.25ml) SQ every other day, Week 3-4: 0.125mg (0.5ml) SQ every other day, Week 5-6: 0.1875mg (0.75ml) SQ every other day, Week 7+: 0.25mg (1ml) SQ every other day <input type="checkbox"/> Maintenance Dose: Inject 0.25mg (1ml) SQ every other day	QS for titration 28-day supply	None _____
<input type="checkbox"/> Copaxone*	<input type="checkbox"/> 20mg PFS <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 20mg SQ daily <input type="checkbox"/> Inject 40mg SQ three times a week	30-day supply 28-day supply	_____ _____
<input type="checkbox"/> Extavia*	0.3mg Vial	<input type="checkbox"/> Dose Titration: Week 1-2: Inject 0.0625mg (0.25ml) SQ every other day, Week 3-4: 0.125mg (0.5ml) SQ every other day, Week 5-6: 0.1875mg (0.75ml) SQ every other day, Week 7+: 0.25mg (1ml) SQ every other day <input type="checkbox"/> Maintenance Dose: Inject 0.25mg (1ml) SQ every other day	QS for titration 30-day supply	None _____
<input type="checkbox"/> Glatopa*	<input type="checkbox"/> 20mg PFS <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 20mg SQ daily <input type="checkbox"/> Inject 40mg SQ three times a week	30-day supply 28-day supply	_____ _____
<input type="checkbox"/> Glatiramer Acetate	<input type="checkbox"/> 20mg PFS <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 20mg SQ daily <input type="checkbox"/> Inject 40mg SQ three times a week	30-day supply 28-day supply	_____ _____
<input type="checkbox"/> Ocrevus*	300mg Vial	<input type="checkbox"/> Initial: Infuse 300mg IV on Day 1 and on Day 15 <input type="checkbox"/> Maintenance: Infuse 600mg IV every 6 months	2 vials 2 vials	None _____
<input type="checkbox"/> Plegridy*	<input type="checkbox"/> Starter Pack <input type="checkbox"/> PEN <input type="checkbox"/> PFS <input type="checkbox"/> 125mcg PFS <input type="checkbox"/> 125mcg PEN	<input type="checkbox"/> Dose Titration: Inject 63mcg SQ on Day 1, then 94mcg SQ on Day 15. Inject 125mcg on Day 29 and every 14 days thereafter <input type="checkbox"/> Maintenance Dose: Inject 125mcg SQ every 14 days	28-day supply 28-day supply	None _____
<input type="checkbox"/> Rebif	<input type="checkbox"/> Titration Rebidoso <input type="checkbox"/> Titration Pack (PFS) <input type="checkbox"/> 22mcg/0.5mL Rebidoso <input type="checkbox"/> 22mcg/0.5mL PFS <input type="checkbox"/> 44mcg/0.5mL Rebidoso <input type="checkbox"/> 44mcg/0.5mL PFS	<input type="checkbox"/> Dose Titration: Week 1-2: Inject 8.8mcg SQ TIW, Week 3-4: 22 mcg SQ TIW, Week 5+: 44mcg SQ TIW <input type="checkbox"/> Maintenance Dose: Inject 44 mcg SQ TIW <input type="checkbox"/> Other: _____	28-day supply 28-day supply	None _____ _____
<input type="checkbox"/> Other				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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