Apollo Specialty Pharmacy

Multiple Sclerosis Injectable Agents

Phone: 973-350-6155 Fax: 973-556-1560

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

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

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Start Date	End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription	Directions, Quantity, Form			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) subq every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subq every other day.	☐ 14 x 0.3 mg	Vials	0
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) subq every other day; Week 7-8: Inject 0.25 mg (1 mL) subq every other day.			0
	☐ Inject 0.25 mg (1 mL) subq every other day			
☐ **Copaxone®** (glatiramer acetate)	☐ Inject 20 mg subq once daily ☐ Inject 40 mg subq three times per week at least 48 hours apart	☐ 30 x 20 mg ☐ 12 x 40 mg	PFS	
☐ **Extavia®** (interferon beta-1b)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subq every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subq every other day.	☐ 15 x 0.3 mg	Vials	0
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) subq every other day; Week 7-onward: Inject 0.25 mg (1 mL) subq every other day.			0
	☐ Inject 0.25 mg (1 mL) subq every other day			
☐ **Glatopa™** (glatiramer acetate)	☐ Inject 20 mg subq once daily	☐ 30 x 20 mg	PFS	
☐ **Lemtrada®** (alemtuzumab)	To order Lemtrada®, please see the Genzyme form at lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf Phone: 855-676-6326 Fax: 855-557-2478			
☐ **Rebif®** (interferon beta-1a)	☐ Week 1-2: Inject 4.4 mcg (0.1 mL) subq three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subq three times per week.	☐ 6 x 8.8 mcg ☐ 6 x 22 mcg	PFS	0
	☐ Week 5 and thereafter: Inject 22 mcg subq three times per week	☐ 12 x 22 mcg	☐ Autoinjectors ☐ PFS	
	☐ Week 1-2: Inject 8.8 mcg (0.2 mL) subq three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subq three times per week.	☐ 6 x 8.8 mcg ☐ 6 x 22 mcg	☐ Autoinjectors ☐ PFS	0
	☐ Week 5 and thereafter: Inject 44 mcg subq three times per week	☐ 12 x 44 mcg	☐ Autoinjectors ☐ PFS	
☐ **Plegridy®** (peginterferon beta-1a)	☐ Inject 63 mcg subq on day 1; then inject 94 mcg on day 15	☐ 1 x 63 mcg ☐ 1 x 94 mcg	☐ Pens ☐ PFS	0
	☐ Inject 125 mcg subq on day 29 and every two weeks thereafter	☐ 2 x 125 mcg	☐ Pens ☐ PFS	
☐ **Tysabri®** (natalizumab)	Complete MS TOUCH / Tysabri Enrollment Form at https://www.tysabrihcp.com/en_us/home/therapy/touch.html			
☐ **Zinbryta™** (daclizumab)	To order, please see the Zinbryta™ forms at https://www.zinbrytarems.com/			

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other _____

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

Prescriber's Signature: _____ Date: _____

I authorize Apollo Pharmacy 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 Apollo Pharmacy.

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 under applicable 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 this information. If you received this communication in error, please notify the sender immediately by calling 973-350-6155 to obtain instructions as to the proper destruction of the transmitted material. Thank you.

Copyright © 2018 by Apollo Pharmacy. All rights reserved.

Reset Form