

## **Multiple Sclerosis**

Call: (877) 883-1392 Fax: (256) 429-2221

	Patient Informat	ion: Name	DOR: Gender: OM OF Last 4 of SSN:			
Prescriber Information: Name:   Address:   City:						
Prescriber Information: Name:   Address:   City:	Fmail:	Ht: Wt: Care Gi	ver: Allergies: ONo Known O See Attache	d Charts		
Statement of Medical Necessity (Please Attach All Medical Documentation)  Date of Diagnosis: ICD-10: What is the severity of patient's disease?  O RRINS OSPINS OPPINS ORMS Pregnancy Test: O Positive O Negative Past Failed Therapies:  Is the medication being used with another disease-modifying therapy for MS? O No O'ves: If yes, which medication(s): Is the patient ineligible for all other therapies due to the severity of their MS? O No O'ves: Contraindication(s): One O'ves o'ves the patient of the patient in the severity of their MS? O No O'ves: Contraindication(s): One O'ves o'ves the market of the MS? O No O'ves: O No O'ves o'v						
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Product Delivery: O Patient's Home O Physician's Office O Pharmacy to Coordinate	-			_		
Prescription Information   Medication   Dosage & Strength   Directions   O along Prefilled Syringe   O along Prefilled Autoinjector   O iteration: Inject 7.5mcg SC on week 1, 15mcg on week 2, 22.5mcg   O iteration: Inject 3.5mcg SC on week 4 and every week thereafter   O newek 3, 30mcg on week 4 and every week thereafter   O newek 3, 30mcg on week 4 and every week thereafter   O newek 3, 30mcg on week 3, 30mcg on week 4, 4 and every week thereafter   O newek 3, 30mcg on week 3, 30mcg on week 4, 4 and every week thereafter   O newek 3, 30mcg on week 3, 30mcg on week 3, 30mcg on week 4, 4 and every week 4 and every other day 6 on week 3, 30mcg on week 4, and every other day 6 on week 3, 30mcg on week 4, and every other day 6 on week 3, 30mcg on week 4, and every other day 6 on week 9, 4, then 0.5ml every other day on weeks 5 & 6, then one fill syringe yeer yother day and every 4 week 9 onewel 4 the 4 and 8 one 4 then 2 one 4		_	• • • • • • • • • • • • • • • • • • • •			
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O Extavia  □ Capaxone	O Betaseron	O 0.3mg Lyophilized Powder	,			
O Extavia   day on weeks 5 & 6, then one full syringe every other day after.   O Continuation: Inject 0.25mg (Imil) SC every other day   30   O Inject 20 mg SC daily   30   O Inject 40mg SC three times weekly at least 48 hours apart   12   O Dalfampridine   O 10mg Tablets   O Recommended: Take 1 tablet twice daily (approximately 12 hours apart) with or without food   O Other:   O 0.5mg Capsules   O 0.5mg Ca	0 201400.011		, ,			
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