Star Discount Pharmacy specialty care

Multiple Sclerosis

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

Patient Information: Name: _____ DOB: _____ Gender: ○M ○F Last 4 of SSN:
Address: _____ City: _____ State: ____ Zip: _____ Phone: _____ Alt. Phone: _____
Email: _____ Ht: ____ Wt: ____ Care Giver: _____ Allergies: ○No Known ○See Attached Charts

Prescriber Information: Name: _____ Address: _____ City: _____
State: _____ Zip: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____ **ICD-10**: _____ **What is the severity of patient's disease?** _____
○RRMS ○SPMS ○PPMS ○PRMS **Pregnancy Test**: ○Positive ○Negative **Past Failed Therapies**: _____
Is the medication being used with another disease-modifying therapy for MS? ○No ○Yes If yes, which medication(s): _____
Is the patient ineligible for all other therapies due to the severity of their MS? ○No ○Yes **Contraindication(s)**: ○No ○Yes _____
If Relapse Remitting: Has the patient experienced a first clinical episode? ○No ○Yes ○Attach MRI results. Date: _____
Injection Training: ○Pharmacist to Provide Training ○Patient Trained in MD Office ○Manufacturer Nurse Support
Product Delivery: ○Patient's Home ○Physician's Office ○Pharmacy to Coordinate

Prescription Information

Medication	Dosage & Strength	Directions	Qty	Ref
○ Avonox	○ 30mcg Prefilled Syringe ○ 30mcg Prefilled Autoinjector	○ **Titration**: Inject 7.5mcg SC on week 1, 15mcg on week 2, 22.5mcg on week 3, 30mcg on week 4 and every week thereafter	1 Kit	0
		○ Inject 30mcg IM every week	1 Pk	
○ Betaseron ○ Extavia	○ 0.3mg Lyophilized Powder for Reconstitution	○ **Titration**: Inject SQ 0.25ml every other day for weeks 1 & 2, then 0.5ml every other day on weeks 3 & 4, then 0.75ml every other day on weeks 5 & 6, then one full syringe every other day after.	1 kit	
		○ **Continuation**: Inject 0.25mg (1ml) SC every other day		
○ Capaxone ○ Glatopa	○ 20mg Prefilled Syringe ○ 40mg Prefilled Syringe	○ Inject 20 mg SC daily	30	
		○ Inject 40mg SC three times weekly at least 48 hours apart	12	
○ Dalfampridine ○ ER	○10mg Tablets	○ **Recommended**: Take 1 tablet twice daily (approximately 12 hours apart) with or without food	60	
		○ Other:		
○ Gilenya	○ 0.25mg Capsules ○ 0.5mg Capsules	○ **[Pediatric]** 10 years of age and above weighing <40kg: Take one 0.25mg cap by mouth once daily with or without food ○ **[Pediatric and Adult]** 10 years of age and above weighting >40kg: Take one 0.5mg cap by mouth once daily with or without food		
		○ Other:		
○ Kesimpta	○ 20mg/0.4ml Prefilled Pen ○ 20mg/0.4ml Prefilled Syringe	○ **Induction**: Inject 20mg SC on Week 0, 1, and 2	3	0
		○ **Maintenance**: Inject 20mg SC on day 29 and every 4 weeks thereafter	1	
○ Plegridy	○ Starter Pack: 63mcg/0.5ml and 94mcg/0.5ml Prefilled Pens ○ Starter Pack: 63mcg/0.5ml and 94mcg/0.5ml Prefilled Syringes	○ **Titration**: Inject 63mcg (0.5ml) SC on day 1, then 94mcg (0.5ml) SC on day 12, then inject 125mcg (0.5ml) SC on day 29 and every 14 days thereafter.	1 Pack	0
	○ 125mcg/0.5ml Prefilled Pens ○ 125mcg/0.5ml Prefilled Syringes	○ Inject 125mcg (0.5ml) SC every 14 days	2	
○ Rebif	○ Titration Pack Rebidose Autoinjectors ○ Titration Pack Prefilled Syringes	○ **Titration Pack**: Inject 8.8mcg (0.2ml) dose SC three times weekly on weeks 1 & 2; then 22mcg (0.5ml) dose SC three times weekly on weeks 3 & 4.	1 Pack	0
	○ 22mcg Prefilled Syringe ○ 44mcg Prefilled Syringe ○ Rebidose 22mcg Autoinjector ○ Rebidose 44mcg Autoinjector	○ **22mcg SC 3 times per week maintenance dose:** Weeks 1 & 2: Inject 4.4mcg 3 times per week Weeks 3 & 4: Inject 11mcg 3 times per week Weeks 5 and onward: Inject 22mcg 3 times per week ○ **For 44mcg SC 3 times per week maintenance dose:** Weeks 1 & 2: Inject 8.8mcg 3 times per week Weeks 3 & 4: Inject 22mcg 3 times per week Weeks 5 and onward: Inject 44mcg 3 times per week		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.