



Today's Date: _____ Needed by: _____ Name: _____ Phone: _____

Patient Demographic: (Provide the following or attached demographic sheet) Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Alt. Phone: _____ SS#: _____ Date Birth: _____ Gender: _____ Height: _____ Weight: _____ BSA: _____ m2	Prescriber: (Provide as much information as possible) Prescriber's Name: _____ Group/Hospital: _____ Specialty: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Alt. Contact Name: _____ Phone: _____ Position: _____
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Insurance Information (Please copy and attach the front and back of the Insurance Card):
 Primary Insurance Name: _____ ID#: _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____
 No Insurance Patient will pay out of pocket Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):
 Patient Address First Fill Physician's Office, Refill to Patient Address Patient will pick up at Pharmacy

Diagnosis (ICD -10 code): G35 Multiple Sclerosis Other: _____

Injection Training & Educational Needs: Specialty Pharmacy Injection Training Requested
Requested OR (Please Choose only one) Physician's Office already trained Patient Patient is already independently Injecting

Patient Allergies/ Allergic reactions:
 1. _____ 2. _____

Prior (Failed) Medications (Reason for D/C):
 1. _____ 2. _____

Medication	Dose / Strength	Direction	Quantity	Refills
<input type="checkbox"/> Avonex	<input type="checkbox"/> 30 mcg PF Syr. <input type="checkbox"/> 30 mcg Pen (Single Doses) <input type="checkbox"/> 30 mcg Vial Single Dose Vial	<input type="checkbox"/> Inject 30 mcg IM once a week	<input type="checkbox"/> 28-days (1 kit) <input type="checkbox"/> 84- days (3 kits)	
<input type="checkbox"/> Aubagio	<input type="checkbox"/> 7mg <input type="checkbox"/> 14mg	<input type="checkbox"/> Take one tablet by mouth once a day	<input type="checkbox"/> 28 day supply (1 box) <input type="checkbox"/> 84 day supply (3 boxes)	
<input type="checkbox"/> Betaseron	<input type="checkbox"/> 0.3mg	<input type="checkbox"/> Inject 0.25mg (1mL) SC every other day <input type="checkbox"/> Dose Titration: <input type="checkbox"/> Weeks 1-2: Inject 0.0625 mg/ 0.25mL SC QOD <input type="checkbox"/> Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD <input type="checkbox"/> Weeks 5-6: Inject 0.1875 mg/ 0.75 mL SC QOD <input type="checkbox"/> Weeks 7+ : Inject 0.25 mg / 1mL SC QOD <input type="checkbox"/> Other : _____	<input type="checkbox"/> 28-Days (1 Kit of 14 Vials) <input type="checkbox"/> 84 - Days (3 Kits of 14 Vials)	
<input type="checkbox"/> Copaxone	<input type="checkbox"/> 20mg PF SYR	<input type="checkbox"/> Inject 20 mg SC daily	<input type="checkbox"/> 30 - Days (1 Kit) <input type="checkbox"/> 90 - Days (3 Kits)	
	<input type="checkbox"/> 40mg PF SYR	<input type="checkbox"/> Inject 40 mg SC three times a week	<input type="checkbox"/> 28 - Days (12 Syr) <input type="checkbox"/> 84 - Days (36 Syr)	
<input type="checkbox"/> Extavia	<input type="checkbox"/> 0.3mg	<input type="checkbox"/> Inject 0.25mg (1mL) SC every other day <input type="checkbox"/> Dose Titration: <input type="checkbox"/> Weeks 1-2: Inject 0.0625 mg/ 0.25mL SC QOD <input type="checkbox"/> Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD <input type="checkbox"/> Weeks 5-6: Inject 0.1875 mg/ 0.75 mL SC QOD <input type="checkbox"/> Weeks 7+ : Inject 0.25 mg / 1mL SC QOD <input type="checkbox"/> Other : _____		
<input type="checkbox"/> Gilenya	<input type="checkbox"/> 0.5mg	<input type="checkbox"/> Take one capsule by mouth once daily	<input type="checkbox"/> 30 - Days (1 Bottle) <input type="checkbox"/> 90 - Days (3 Bottles)	
<input type="checkbox"/> Glatopa	<input type="checkbox"/> 20mg PF Syr	<input type="checkbox"/> Inject 20mg SC Daily	<input type="checkbox"/> 30 - Days (1 Kit) <input type="checkbox"/> 90 - Days (3 Kits)	

Sharps Package: (Sterile sponges, alcohol swabs, sharps container)

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorizati on designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature

_____/_____/_____
Date

Medication	Dose / Strength	Direction	Quantity	Refills
<input type="checkbox"/> Lemtrada	<input type="checkbox"/> 12mg/1.2mL Vial	<input type="checkbox"/> Administer IV over 4 hours for 2 treatment courses: <input type="checkbox"/> 1st Course: 12mg / day on 5 Consecutive Days <input type="checkbox"/> 2nd Course: 12mg / day on 3 Consecutive Days 12 months after first treatment course	<input type="checkbox"/> 1st Course: 5-day supply (5 Vials) <input type="checkbox"/> 2nd Course: 3-day supply (3 Vials)	
<input type="checkbox"/> Ocrevus	<input type="checkbox"/> 300mg / 10 mL (30 mg/mL) Single Dose Vial	<input type="checkbox"/> Induction Dose: Infuse 300 mg IV, followed; by two weeks later by a second 300 mg IV infusion <input type="checkbox"/> Maintenance Dose: Infuse 600 mg IV every 6 months	<input type="checkbox"/> 2 Vials <input type="checkbox"/> _____	
<input type="checkbox"/> Plegridy	<input type="checkbox"/> Pen Starter Pack (one 63 mcg pen & one 94 mcg pen) <input type="checkbox"/> Prefilled Syringe Starter Pack (one 63 mcg pre-filled syringe & one 94 mcg pre-filled syringe)	<input type="checkbox"/> Day 1: Administer 63 mcg / 0.5 mL SC <input type="checkbox"/> Day 15: Administer 94 mcg / 0.5 mL SC	<input type="checkbox"/> 28 day supply	
	<input type="checkbox"/> Pen Maintenance Pack (two 125 mcg pens) <input type="checkbox"/> Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes)	<input type="checkbox"/> Administer 125 mcg / 0.5 mL SC every 14 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 28 day supply (1 pack) <input type="checkbox"/> 84 day supply (1 Kit)	
<input type="checkbox"/> Rebif	<input type="checkbox"/> Titration Pack (six 8.8 mcg & Six 22 mcg PF Syr) <input type="checkbox"/> Rebidose Titration Pack (Six 8.8 mcg PF autoinjectors & Six 22 mcg PF autoinjectors)	Weeks 1 - 2: Inject 8.8 mcg SC three times a week. Weeks 3 - 4: Inject 22 mcg SC three times a week.	28 - days (1 kit)	
	<input type="checkbox"/> 22 mcg PF Syr. <input type="checkbox"/> Rebidose 22 mcg PF autoinjector <input type="checkbox"/> 44 mcg PF Syr. <input type="checkbox"/> Rebidose 44 mcg PF autoinjector	Inject 44 mcg SC three times a week. Other: _____	28 - days (1 kit) 84 - days (3 kits)	
<input type="checkbox"/> Tecfidera	<input type="checkbox"/> Titration Starter Pack (14 capsules of 120 mg & 46 capsules of 240 mg)	Take one 120 mg capsule by mouth twice a day for 7 days, followed by one 240 mg capsule by mouth twice a day	30 day supply	
	<input type="checkbox"/> 120 mg capsules <input type="checkbox"/> 240 mg capsules	<input type="checkbox"/> Take 240 mg capsule by mouth twice a day <input type="checkbox"/> Other: _____	<input type="checkbox"/> 7 day supply <input type="checkbox"/> 30 day supply <input type="checkbox"/> 90 day supply	
<input type="checkbox"/> Tysabri	Please complete an MS Touch / Tysabri enrollment form			
<input type="checkbox"/> Zinbryta	Please complete a copy of the Zinbryta Patient Enrollment Form by accessing www.Zinbryta.com or calling 1-800-456-2255			
<input type="checkbox"/> Other:				
<input type="checkbox"/> Sharps Package: (Sterile sponges, alcohol swabs, sharps container)				
By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies				

Prescriber Signature

_____/_____/_____
Date