

Phone: 843-352-7662 | Fax 843-898-3992 | Backup Fax 843-352-7632 | 1501 Belle Isle Ave #150 Mt. Pleasant SC 29464

PATIENT INFORMATION – PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: _____ Last Name: _____ Date of Birth: _____ M F
 Street Address: _____ City: _____ State: _____ Zip: _____
 Cell Phone: _____ SSN: _____ Patient Preferred Language: English Spanish _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone Number: _____ Fax Number: _____ Contact Person: _____
 Office's Preferred Method of Contact: Phone Fax Portal Email: _____ Other: _____

PATIENT CLINICAL INFORMATION / HISTORY – PLEASE FORWARD CHART NOTES AND RELEVANT LABS

Diagnosis: Multiple Sclerosis ICD 10: G35 Other: _____ Weight: _____ Height: _____
 Relapsing Remitting Primary Progressive Secondary Progressive Progressive Relapsing
 Previous Medications: _____ Drug Allergies: _____

PRESCRIBING INFORMATION

NEW RESTART CONTINUING | SHIPPING PREFERENCE: Deliver medication to patient Deliver medication to MD

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> AVONEX	<input type="checkbox"/> 30mcg/0.5mL PFS <input type="checkbox"/> 30mcg/0.5mL Pen	<input type="checkbox"/> Inject 30mcg IM once weekly		
<input type="checkbox"/> BETASERON	<input type="checkbox"/> 0.3mg Vial	<input type="checkbox"/> <u>Induction Dosing</u> Weeks 1-2: Inject 0.0625mg (0.25mL) SC every other day Weeks 3-4: Inject 0.125mg (0.5mL) SC every other day Weeks 5-6: Inject 0.1875mg (0.75mL) SC every other day Weeks 7+: Inject 0.25mg (1mL) SC every other day <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 0.25mg (1mL) SC every other day		
<input type="checkbox"/> COPAXONE	<input type="checkbox"/> 20mg/mL PFS <input type="checkbox"/> 40mg/mL PFS	<input type="checkbox"/> Inject 20mg SC once daily <input type="checkbox"/> Inject 40mg SC three times weekly (48 hours apart)		
<input type="checkbox"/> DALFAMPRIDINE	<input type="checkbox"/> 10mg Tablet	<input type="checkbox"/> Take 10mg by mouth twice daily		
<input type="checkbox"/> EXTAVIA	<input type="checkbox"/> 0.3mg Vial	<input type="checkbox"/> <u>Induction Dosing</u> Weeks 1-2: Inject 0.0625mg (0.25mL) SC every other day Weeks 3-4: Inject 0.125mg (0.5mL) SC every other day Weeks 5-6: Inject 0.1875mg (0.75mL) SC every other day Weeks 7+: Inject 0.25mg (1mL) SC every other day <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 0.25mg (1mL) SC every other day		
<input type="checkbox"/> GILENYA	<input type="checkbox"/> 0.5mg Capsule	<input type="checkbox"/> Take 0.5mg by mouth once daily		
<input type="checkbox"/> GLATIRAMER	<input type="checkbox"/> 20mg/mL PFS <input type="checkbox"/> 40mg/mL PFS	<input type="checkbox"/> Inject 20mg SC once daily <input type="checkbox"/> Inject 40mg SC three times weekly (48 hours apart)		
<input type="checkbox"/> GLATOPIA	<input type="checkbox"/> 20mg/mL PFS <input type="checkbox"/> 40mg/mL PFS	<input type="checkbox"/> Inject 20mg SC once daily <input type="checkbox"/> Inject 40mg SC three times weekly (48 hours apart)		
<input type="checkbox"/> KESIMPTA	<input type="checkbox"/> 20mg/0.4mL Sensoready Pen	<input type="checkbox"/> <u>Induction Dose</u> : Inject 20mg SC at week 0, 1, and 2 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 20mg SC once monthly (starting on week 4)		
<input type="checkbox"/> MAYZENT	<input type="checkbox"/> 0.25mg Tablet <input type="checkbox"/> 1mg Tablet <input type="checkbox"/> 2mg Tablet	CYP2C9 GENOTYPE *1/*1, *1/*2, or *2/*2 <input type="checkbox"/> <u>Induction Dose</u> : Take 0.25mg by mouth once daily on Days 1 and 2, then take 0.5mg by mouth once daily on Day 3, then take 0.75mg by mouth once daily on Day 4, then take 1.25mg by mouth once daily on Day 5 <input type="checkbox"/> <u>Maintenance Dose</u> : Take 2mg by mouth once daily beginning on Day 6 CYP2C9 GENOTYPE *1/*3 or *2/*3 <input type="checkbox"/> <u>Induction Dose</u> : Take 0.25mg by mouth once daily on Days 1 and 2, then take 0.5mg by mouth once daily on Day 3, then take 0.75mg by mouth once daily on Day 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Take 1mg by mouth once daily beginning on Day 5	12	0
<input type="checkbox"/> OCREVUS	<input type="checkbox"/> 300mg/10mL Vial	<input type="checkbox"/> <u>Induction Dose</u> : Infuse 300mg via IV on week 0 and week 2 <input type="checkbox"/> <u>Maintenance Dose</u> : Infuse 600mg via IV every 6 months	2	0

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I Authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process/appeals if necessary, in doing so, to release clinical information via phone/fax to appropriate third party payor.