Neurology / Multiple Sclerosis

Fax Referral to: 512-487-5033 Phone: 512-432-5190
Email Referral to: april@martinsspecialtypharmacy.com

Patient Information

Patient Information	
Patient Name	
Address	
City, State, Zip	
Primary Phone	Emergency Contact Name & Phone Number
Date of Birth	☐ Male ☐ Female
Social Security #	

Prescriber Information

Prescriber Information		
Prescriber Name		
DEA#	NPI#	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

Insurance Information:

Please fax FRONT and BACK copy of prescription and medical insurance cards.

Diagnosis/Clinical Information:

Please fax recent clinical notes, labs and tests with this prescription to expedite the Prior Authorization

Diagnosis: ☐ G35 Multiple Sclerosis ☐ Other: ICD code ________ Condition: ________________ Date of first demyelinating event: ________

Has the patient been previously treated for this condition? ☐Yes ☐No Prior failed Medication: ________________________________

Is the patient currently on therapy? ☐Yes ☐No Medication(s): ________________________________

Will patient stop current therapy before starting new therapy? ☐Yes ☐No Stop Date: __________ Waiting period for new therapy: ________

Other medications patient taking: ________________________________

Allergies: ________________________________ Height: __________ Weight: __________

Prescription Information

Medication	Dose / Strength	Directions	Quantity	Refills
Aubagio®	☐ 7mg Tablets ☐ 14mg Tablets	☐ 1 tablet by mouth daily	☐ 4 week supply	______
Avonex®	☐ 30mcg Prefilled Syringe ☐ 30mcg Single Dose Vial ☐ 30mcg Avonex Pen (single dose)	☐ Inject 30mcg **Intramusculary** once a week	☐ 4 week supply	______
Betaseron®	☐ 0.3mg Prefilled Syringe	☐ Initial Dose Tritration: Weeks 1-2: 0.0625mg (0.25ml) Sub-Q every other day Weeks 3-4: 0.125mg (0.5ml) Sub-Q every other day Weeks 5-6: 0.1875mg (0.75ml) Sub-Q every other day Week 7 +: 0.25mg (1ml) Sub-Q every other day	☐ 4 week supply	0
		☐ Inject 0.25mg (1ml) Sub-Q every other day		______
Copaxone®	☐ 20mg Prefilled Syringe ☐ 40mg Prefilled Syringe	☐ Inject 20mg Sub-Q once a day ☐ Inject 40mg Sub-Q 3 times a week	☐ 4 week supply	______
Extavia®	☐ 0.3mg Prefilled Syringe	☐ Initial Dose Titration: (see Betaseron schedule above) ☐ Inject 0.25mg (1ml) Sub-Q every other day	☐ 4 week supply	______
Gilenya®	☐ 0.5mg Capsule	☐ Take 1 capsule daily	☐ 4 week supply	______
Plegridy®	☐ Starter Pack - Pen Injector ☐ Starter Pack - Prefilled Syringe	☐ Day 1: Inject 63mcg/0.5ml Sub-Q; Day 2: inject 94mcg/0.5ml Sub-Q; Dat 29: inject 125mcg/0.5ml then every 14 days	☐ Starter Pack - 28 day supply	0
	☐ Pen Injector 125mcg x 2 ☐ Prefilled Syringe 125mcg x 2	☐ Inject 125mcg/0.5ml Sub-Q every 14 days ☐ Other: ________________	☐ 4 week supply	______
Rebif®	☐ Titration Pack	☐ Week 1&2: Inject 8.8mcg/0.2ml Sub-Q 3 times a week (48hrs apart) ☐ Week 3&4: Inject 22mcg/0.5ml Sub-Q 3 times a week (48hrs apart)	☐ 4 week supply	0
	☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe	☐ Inject Sub-Q 3 times a week ☐ Other: ________________	☐ 4 week supply	______
Tecfidera®	☐ Starter Pack	☐ Take a 120mg capsule by mouth twice daily x7 days, then a 240mg capsule by mouth twice daily	☐ Titration Starter Pack - 30 day supply	0
	☐ 120mg Capsule ☐ 240mg Capsule	☐ Other: ________________ ☐ Take 1 capsule by mouth twice daily	☐ 4 week supply	______

________________________________ ______________

Prescriber's Signature (no stamp signature) If Brand required check ☐ DAW Date

By signing this form, you are authorizing Martin's Specialty Pharmacy and its representatives to act as your prior authorization designated agent to work with prescription and medical insurance companies to initiate and execute the process.

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