Phone: 417-719-4510
Fax: 417-893-3908
specialty.alpspharmacy.com

Multiple Sclerosis (D-Z)

PATIENT INFORMATION

Patient Name: ______
Address: ______
City, State, ZIP: ______
Home Phone: ______ Alternate Phone: ______
Caregiver: ______ Email : ______
DOB: ______ Social Security#: ______
Gender: ☐ Male ☐ Female Comorbidities: ______
Height: ______ Weight: ______ Allergies: ______

PRESCRIBER INFORMATION

Prescriber's Name: ______
Address: ______
City, State, ZIP: ______
Phone: ______ Fax: ______
NPI: ______ Tax-ID# : ______
DEA: ______
Office Contact: ______ Phone: ______
Contact Email: ______

INSURANCE INFORMATION

Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.

CLINICAL INFORMATION **[Please fax all pertinent clinical and lab information and/or attach separate sheet if needed.]**

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ ______ ☐ ______
Type: ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Secondary-progressive ☐ Primary-progressive ☐ Progressive-relapsing
Hepatic impairment present: ☐ Yes ☐ No AST: ______U/L ALT: ______U/L Bilirubin: ______mg/dL Lab Date: ______ ☐ HCV ☐ ______

Prior Therapy ☐ Yes ☐ No	Approx. Therapy Start/End Dates	Reason for Discontinuation of Therapy
______	______ to ______	______
______	______ to ______	______
______	______ to ______	______
______	______ to ______	______
______	______ to ______	______
______	______ to ______	______

Date of Diagnosis: ______
TB test?: ☐ Yes ☐ No Negative TestDate: ______
HBV positive?: ☐ Yes ☐ No If yes, currently treated? ☐ Yes ☐ No
Concomitant Medications: ______
Additional Information: ______
______

PRESCRIPTION INFORMATION

Medication	Directions	Quantity		Refills
☐ Extavia® (Interferon Beta-1B)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) sub-Q every other day; Week 3-4: Inject 0.125 mg (0.5 mL) sub-Q every other day.	☐ 15 x 0.3 mg	☐ Vials	
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) sub-Q every other day; Week 7-onward: Inject 0.25 mg (1 mL) sub-Q every other day.	☐ 15 x 0.3 mg	☐ Vials	
	☐ Inject 0.25 mg (1mL) sub-Q every other day	☐ 15 x 0.3 mg	☐ Vials	
☐ Glatopa® (Glatiramer Acetate)	☐ Inject 20 mg Sub-Q once daily	☐ 30 X 20mg	☐ PFS	
☐ Gilenya® (fingolimod)	☐ Take 0.5 mg once daily by mouth	☐ 30 x 0.5 mg	☐ capsules	
☐ Rebif® (Interferon Beta-1A)	☐ Week 1-2: Inject 4.4 mcg (0.1 mL) sub-Q three times per week; Week 3-4: Inject 11 mcg (0.25 mL) sub-Q three times per week.	☐ 6 x 8.8 mcg / 6 x 22 mcg	☐ PFS	
	☐ Week 5 and thereafter: Inject 22 mcg sub-Q three times per week	☐ 12 x 22 mcg	☐ Autoinjectors ☐ PFS	
	☐ Week 1-2: Inject 8.8 mcg (0.2 mL) sub-Q three times per week; Week 3-4: Inject 22 mcg (0.5 mL) sub-Q three times per week.	☐ 6 x 8.8 mcg / 6 x 22 mcg	☐ Autoinjectors ☐ PFS	
	☐ Week 5 and thereafter: Inject 44 mcg sub-Q three times per week	☐ 12 x 44 mcg	☐ Autoinjectors ☐ PFS	

☐ Other Medication: ______ Dose: ______ Quantity: ______ Refills: ______
Direction(s): ______

INJECTION TRAINING

☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRESCRIPTION DELIVERY

☐ Patient's Home ☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: ______ Needs by Date: ______

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: ______ Date: ______ Prescriber's Signature: ______ Date: ______
PRODUCT SUBSTITUTION PERMITTED ***Dispense As Written***

CONFIDENTIALITY NOTICE

The information contained in this for is intended only for the use of individual or entity named. It contains confidential information, legally privileged, that may be protected health information under federal and state laws. If you are not the intended recipient, you are hereby notified that any dissemination, copying, or distribution of this communication is strictly prohibited. If you have received this form in error, please notify the sender and immediately destroy this communication.

Disclaimer: Alps can accept only original prescription drug orders from patients, and faxed prescriptions can be accepted only from the prescribing practitioners.