MULTIPLE SCLEROSIS PRESCRIPTION FORM (A-L)

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

altScripts Specialty Pharmacy
1636 Miller Park Way, West Milwaukee, WI 53214
Phone: 414-385-9500 Fax: 414-385-7200

Patient Information: please provide a copy of the patient's insurance card or information					
Patient Name:	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**	
Address:	**City:**	**State:**	**Zip Code:**	**Phone:**	
Insurance:	**Subscriber's name:**	**ID#:**	**Group #:**		
Allergies: ☐ NKDA ☐ List allergies:					

Referral Expectations		
Injection training: □ Please complete by pharmacy staff □ Completed by physician office staff □ Completed by home nurse/manuf program	**Manufacturer care kit:** □ Provide to patient □ Provided by MD office □ Please do not provide	**Manufacturer program enrollment** □ Complete at pharmacy □ Completed by physician office staff □ Please do not enroll

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization			
Diagnosis / ICD-10:		**Prior treatment - include name and date of prior treatment:**	
Current treatment:		**Name and date of initiation:**	
Number of relapses in past year:	**Last MRI date:**	**Pregnant or Planning Pregnancy:** ☐ Y ☐ N	**Serum Creatinine:**

Medication	**Dose / Strength**	**Directions**	**Quantity**	**Refills**
☐ Aubagio ®	☐ 7 mg tablet ☐ 14 mg tablet	☐ Take 7 mg tablet PO once daily ☐ Take 14 mg tablet PO once daily	☐ 4-week supply	
☐ Avonex ®	☐ 30 mcg prefilled syringe (#4) ☐ 30 mcg pen (#4)	☐ Inject 7.5mcg IM day 0, 15mcg IM day 7, 22.5mcg IM day 14, 30mcg IM day 21 and every week there after ☐ Inject IM once weekly	☐ 4-week supply	
☐ Betaseron ®	☐ 0.3 mg vial	☐ Dose titration: weeks 1-2, inject 0.0625 mg/0.25 mL SQ QOD; weeks 3-4, inject 0.125 mg/0.5 mL SQ QOD; weeks 5-6, inject 0.187 mg/0.75 mL SQ QOD; weeks 7+, inject 0.25 mg/1 mL SQ QOD ☐ Maintenance dose: Inject 0.25 mg/1 mL SQ every other day	☐ 4-week supply	
☐ Copaxone ®	☐ 20 mg/mL prefilled syringe ☐ 40 mg/mL prefilled syringe	☐ Inject 20 mg/mL SQ once daily ☐ Inject 40 mg/mL SQ three times per week, at least 48 hours apart	☐ 4-week supply	
☐ dalfampridine (generic Ampyra ®)	☐ 10 mg ER tab	☐ Take 10 mg tablet PO every 12 hours	☐ 4-week supply	
☐ glatiramer acetate	☐ 20 mg/mL prefilled syringe ☐ 40 mg/mL prefilled syringe	☐ Inject 20 mg/mL SQ once daily ☐ Inject 40 mg/mL SQ three times per week	☐ 4-week supply	
☐ Gilenya ®	☐ 0.5 mg capsule	☐ Take 0.5 mg capsule PO once daily	☐ 4-week supply	
☐ Kesimpta ®	☐ 20 mg/0.4 mL single-dose prefilled Sensoready® Pen (3)	☐ Initial dosing of 20 mg by SQ injection at Weeks 0, 1, and 2 ☐ Subsequent dosing of 20 mg by SQ injection once monthly starting at Week 4	☐ 4-week supply	
☐ Lemtrada ®	☐ 12 mg/1.2 mL vial	☐ 12 mg IV for 5 days ☐ 12 mg IV for 3 days		

Physician Information				
Prescriber name:		**Phone:**	**Office contact name:**	
Prescriber address:	**City:**		**State:**	**Zip:**
NPI:	**DEA:**	**Fax and/or Email:**		
Prescriber signature:		**Date:**	□ **DO NOT SUBSTITUTE**	