MULTIPLE SCLEROSIS PRESCRIPTION FORM

151 Cochituate Rd | Framingham, MA 01701
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Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Sept 2016

Patient Name First Name ____ Middle Name ____ Last Name ____ DOB ____ Weight ____ ☐ Male ☐ Female

Street Address ____ Apt # ____ City ____ State ____ Zip ____

Daytime Tel ____ Evening Tel ____ Cell ____ Email ____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed ____

ICD-10 Diagnosis ☐ G35 Multiple Sclerosis **OR** Other ____ Allergies ____

Patient currently on therapy ☐ Yes ☐ No Date of next blood work ____ Comments ____

Insured's Name ____ Relation to Patient ____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ____

Prescription Card ☐ Yes ☐ No If Yes, Carrier ____ Tel ____ Fax ____ Policy/Group# ____

Bin# ____ Pcn# ____ RXID# ____ RX Group# ____

Prescriber's Name ____ Office Contact ____

Street Address ____ Suite # ____ City ____ State ____ Zip ____

Tel ____ Fax ____ Email ____

License# ____ NPI# ____ UPIN# ____ DEA# ____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AVONEX ADMINISTRATION PACK 30 mcg PreFilled

SIG ☐ Inject 30 mcg IM once weekly
☐ Other ____
QTY # ____ Weeks *(1 pack = 4 week supply)* Refills x ____

BETASERON 0.3 mg Vials

SIG ☐ Inject ____ SC every other day
☐ Other ____
QTY # ____ Weeks *(1 box = 4 week supply)* Refills x ____

COPAXONE

☐ **40 mg/ml Syringe**
SIG ☐ Inject 40mg SC three times weekly
☐ Other ____
☐ **20 mg/ml Syringe**
SIG ☐ Inject 20mg SC once daily
☐ Other ____
QTY # ____ Syringes Refills x ____

EXTAVIA VIALS

SIG ☐ Inject ____ SC every other day
Other ____
QTY # ____ Weeks *(1 box = 4 week supply)* Refills x ____

GILENYA

0.5 mg ____ orally once daily QTY - 28 Refill X ____

REBIF TITRATION PACK 12 syringes

SIG ☐ 8.8 mcg SQ TIW - weeks 1 & 2 ☐ 22 mcg SQ TIW - weeks 3 & 4
Maintenance Dose following week 3 & 4
QTY # ____ Boxes *(1 box = 4 week supply)* Refills x ____

REBIF 22mcg/0.5ml SIG ☐ 22 mg (0.5ml) SQ TIW (48hrs apart)
QTY # ____ Boxes *(1 box = 4 week supply)* Refills x ____

REBIF 44mcg/0.5ml (maintenance) SIG ☐ starting wk 5: 44 mcg (0.5ml) SQ TIW (48hrs apart)
QTY # ____ Boxes *(1 box = 4 week supply)* Refills x ____

OTHER ____

SIG ____ QTY ____ Refills x ____

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ____ **Date** ____

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Please fax completed referral form to **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.

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