SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
FAX: 787-704-2027

Multiple Sclerosis Injectable Agents Enrollment/Prescription Form

Patient Information

Date:_____ Patient SS#:_____ ☐ Male ☐ Female
Patient's First Name:_____ Patient's Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone Number:_____ Alternate Phone Number:_____
DOB:_____ Caregiver:_____ Allergies:_____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Prescription Information

ICD-9 Code: CM 340 Secondary ICD-9 Code:_____ Date of first demyelinating event:_____
Type: ☐ Relapsing-remitting ☐ Secondary-progressive with relapses ☐ Primary-progressive
☐ Secondary-progressive without relapses ☐ Clinically Isolated Syndrome (CIS) ☐ Progressive-relapsing

Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):
Prior therapies:_____ Reason for discontinuation:_____
Other:_____
Date Shipment Needed:_____ **Ship to:** ☐ **Patient** ☐ **Physician/Clinic**

Medication	Strength	Directions	Quantity	Refills
☐ **Avonex® PFS** ☐ **Avonex® SDV** ☐ **Avonex® Pen**	30 mcg	☐ **Titration Dosing** (*available only with SDV or PFS*): Week 1: Inject 7.5 mcg IM once weekly; Week 2: Inject 15 mcg IM once weekly; Week 3: Inject 22.5 mcg IM once weekly; Week 4 and thereafter: Inject 30 mcg IM once weekly	☐ 1 kit=4 PFS ☐ 1 kit=4 SDV	
		☐ Inject 30 mcg IM once weekly	☐ 1 kit=4 PFS ☐ 1 kit=4 SDV ☐ 1 kit=4 pens	_____
☐ **Betaseron®**	0.3 mg	☐ **Titration Dosing:** Weeks 1-2: Inject 0.0625 mg (0.25 mL) SQ every other day; Weeks 3-4: Inject 0.125 mg (0.5 mL) SQ every other day; Weeks 5-6: Inject 0.1875 mg (0.75 mL) SQ every other day; Week 7 and thereafter: Inject 0.25 mg (1 mL) SQ every other day ☐ Inject 0.25 mg (1 mL) SQ every other day	1 kit=14 devices	_____
☐ **Copaxone® PFS**	☐ 20 mg	☐ Inject 20 mg SQ Daily ☐ Other:_____	1 kit=30 PFS	_____
	☐ 40 mg	☐ Inject 40 mg SQ three times per week ☐ Other:_____	1 kit=12 PFS	_____
☐ **Rebif® PFS Titration Pack** ☐ **Rebif® Rebidose® Titration Pack**		☐ **Titration to 22 mcg dose:** Weeks 1-2: Inject 4.4 mcg SQ three times per week; Weeks 3-4: Inject 11 mcg SQ three times per week; Week 5 and thereafter: Inject 22 mcg SQ three times per week ☐ **Titration to 44 mcg dose:** Weeks 1-2: Inject 8.8 mcg SQ three times per week; Weeks 3-4: Inject 22 mcg SQ three times per week; Week 5 and thereafter: Inject 44 mcg SQ three times per week	1 kit = six 8.8 mcg + six 22 mcg devices	
☐ **Rebif® PFS** ☐ **Rebif® Rebidose® Autoinjector**	☐ 22 mcg ☐ 44 mcg	☐ Inject 22 mcg SQ three times per week ☐ Inject 44 mcg SQ three times per week ☐ Other: _____	1 kit=12 devices	_____

Prescriber

Physician's Name (please print):_____ Contact Name: _____
Phone #:_____ Fax #: _____ NPI #:_____
Office Address: _____ City:_____ State:_____ Zip:_____
I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
Physician's Signature:_____ Date:_____