



Multiple Sclerosis Order Form
 2506 Lakeland Drive, Suite 201, Jackson, Mississippi 39232
 Pharmacy phone: (866) 420-4041 Pharmacy fax: (601) 420-4040
 www.transcriptpharmacy.com

Patient Information

Patient name _____
 Address _____
 City _____ State _____ Zip _____
 Home phone _____ Cell _____
 DOB _____ SSN _____
 Drug allergies _____ Male Female

Prescriber Information

Prescriber name _____ Lic# _____
 DEA# _____ Tax ID _____
 Practice name _____
 Address _____ Suite _____
 City _____ State _____ Zip _____
 Office Phone _____ Fax _____

Insurance, Medicare or Medicaid Information

Primary Insurance _____ Secondary Insurance (*If applicable*) _____
 Policy # _____ Group _____ Policy # _____ Group _____
 Insurance phone _____ Insurance phone _____
 Prescription Drug Coverage: Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ PCN/ID# (if avail.) _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

Clinical Information

Diagnosis: Multiple Sclerosis ICD-9: 340 **Other:** _____ This Rx is: New therapy Continuing previous treatment on this agent
 Relapsing Remitting MS (RRMS) Secondary Progressive MS (SPMS) Progressive Relapsing MS (PRMS) Primary Progressive MS (PPMS) Other
 Previous drug therapies tried with dates and results _____

Additional medical justification _____

Drug Name	Prescription Orders (PLEASE CHECK ONE OR MORE)	Quantity	Refills
<input type="radio"/> Avonex® 30mcg/ Syringe	<input type="radio"/> Inject 30mcg intramuscularly once weekly (QW)	28 day supply	Refills
<input type="radio"/> Betaseron® 0.3mg Syringe	<input type="radio"/> Inject 0.25mg subcutaneously every other day (QOD) <input type="radio"/> Other: _____	28 day supply	Refills
<input type="radio"/> Copaxone® 20mg Syringe	<input type="radio"/> Inject 20mg subcutaneously every day (QD)	30 day supply	Refills
<input type="radio"/> Extavia® 0.3mg Vial	<input type="radio"/> Inject 0.25mg subcutaneously every other day (QOD) <input type="radio"/> Other: _____	30 day supply	Refills
<input type="radio"/> Gilenya® 0.5mg Capsule	<input type="radio"/> Take one capsule by mouth daily (QD)	28 day supply	Refills
<input type="radio"/> Rebif® 22 mcg Syringe <input type="radio"/> Rebif® 44 mcg Syringe	<input type="radio"/> Inject 22 mcg subcutaneously three times a week (TIW) <input type="radio"/> Inject 44 mcg subcutaneously three times a week (TIW) <input type="radio"/> Other: _____	28 day supply	Refills
Other medication	Directions	Qty	Refills
Other medication	Directions	Qty	Refills

Currently, Ampyra® and Tysabri® are not available through Transcript Pharmacy

Deliver to: Patient's home MD's office 1st dose to MD's office, remaining refills to patient home Injection training needed? Yes No

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

 Prescriber signature Office contact name (Nurse, MA, Other) Preferred phone number & extension Date