MULTIPLE SCLEROSIS AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PraxisRx

PATIENT INFORMATION

Patient:_____ Caregiver: _____
DOB:_____ ☐ Male or ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Allergies:_____
Address:_____ City:_____ State:_____ Zip:_____
Primary Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell
Email:_____

CLINICAL INFORMATION

ICD-10 Code: G35 Secondary ICD-10 Code: _____ Date of first demyelinating event: _____ /_____ /_____

Type: ☐ Relapse-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:

Prior therapies: _____ Reason for discontinuation: _____
Therapy: ☐ New ☐ Reauthorization Other: _____

PRESCRIPTION INFORMATION

Avonex®	☐ 30mcg Prefilled Syringe 25G 1" Needles ☐ 30mcg Single Dose Vial ☐ 30mcg Avonex Pen (single dose)	☐ Inject 30mcg intramuscularly every week	☐ 4-week supply (1 kit)	Refills: _____
Betaseron®	0.3mg	☐ Inject 0.25mg (1mL) Sub-Q every other day (QOD) ☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25mL Sub-Q QOD • Weeks 3-4: Inject 0.125mg/0.50mL Sub-Q QOD • Weeks 5-6: Inject 0.1875mg/0.75mL Sub-Q QOD • Weeks 7+: Inject 0.25mg/1mL Sub-Q QOD ☐ Other: _____	☐ 28-day supply (1 box) ☐ Other: _____	Refills: _____
Copaxone®	☐ 20mg Prefilled Syringe ☐ 40mg Prefilled Syringe	☐ Inject 20mg Sub-Q daily ☐ Inject 40mg Sub-Q 3 times weekly	☐ 30-day supply (1 kit)	Refills: _____
Extavia®	0.3mg	☐ Inject 0.25mg (1mL) Sub-Q QOD ☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25mL Sub-Q QOD • Weeks 3-4: Inject 0.125mg/0.50mL Sub-Q QOD • Weeks 5-6: Inject 0.1875mg/0.75mL Sub-Q QOD • Weeks 7+: Inject 0.25mg/1mL Sub-Q QOD ☐ Other: _____	☐ 30-day supply (1 kit)	Refills: _____
Gilenya™	0.5mg	☐ Take one 0.5mg capsule every day	☐ 28-day supply (1 box) ☐ Other: _____	Refills: _____
Glatopa™	20mg Prefilled Syringe	☐ Inject 20mg Sub-Q daily	☐ 30-day supply (1 kit)	Refills: _____
Rebif®	☐ Titration Pack (six 8.8mcg & six 22mcg prefilled syringes) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe ☐ Titration Pack Rebidose® (six 8.8 mcg pre-filled autoinjectors and six 22 mcg pre-filled autoinjectors) ☐ Rebidose® 22 mcg Prefilled Autoinjector ☐ Rebidose® 44mcg Prefilled Autoinjector	☐ Weeks 1-2: Inject 4.4 mcg Sub-Q three times weekly; Weeks 3-4: Inject 11 mcg Sub-Q three times weekly; Weeks 5+: Inject 22 mcg Sub-Q three times weekly ☐ Weeks 1-2: Inject 8.8 mcg Sub-Q three times weekly; Weeks 3-4: Inject 22 mcg Sub-Q three times weekly; Weeks 5+: Inject 44 mcg Sub-Q three times weekly ☐ Inject 22 mcg Sub-Q three times weekly ☐ Inject 44 mcg Sub-Q three times weekly	☐ 4-week supply (1 kit) ☐ Other: _____	Refills: _____

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____
Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____
Prescriber: _____ NPI #: _____ Phone #: _____
Fax #: _____ Contact Name: _____
Office Address: _____ City: _____ State: _____ Zip: _____

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: _____ Date: _____