## Publix Specialty Pharmacy #3213 MULTIPLE SCLEROSIS (FORM A)

Patient's First Name:	Patient's Last N	ame:	
Date of Birth:/	Caregiver Name	:	
Address:	City:	State:	Zip:
Primary Phone Number: ()	Alt. Phone Num	ıber: ()	
Clinical Information: [Attach copy of labs and clinical notes]	□ Urgent Reques	st Using Cov	ver My Meds: 🗆 No 🗆 Yes
Diagnosis code: 🛛 G35 (Multiple Sclerosis) 🖓 Other:		Height: $\Box$ cm $\Box$ in	Weight: $\Box kg \Box lb$
Type: $\Box$ Clinically isolated syndrome (CIS) $\Box$ Relapsing - ren	mitting (RRMS)	□ Progressive - relapsing (I	PRMS)
□ Primary progressive (PPMS) □ Secondary prog	gressive (SPMS)		
Treatment status: $\Box$ New to therapy $\Box$ Continuation of therapy,	start date:/	/	

Allergies:  $\Box$  NKDA  $\Box$  Other: \_\_\_\_\_

Prior therapies, reason for discontinuation, treatment dates: \_

Other pertinent past medical history and/or drug therapy: \_\_\_\_

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
Dimethyl	□ Starter Pack (120 mg & 240 mg)	Initial: Take 120 mg PO twice daily for 7 days, then take 240 mg PO twice daily	30 days	0
Tumarate	□ 240 mg capsule	Maintenance: Take 240 mg PO twice daily	□ 30 days □ 90 days	
Copaxone (glatiramer)	□ 20 mg/mL PFS	Inject 20 mg SC one time daily	□ 30 days □ 90 days	
□ Glatopa (glatiramer)	□ 40 mg/mL PFS	Inject 40 mg SC three times per week at least 48 hours apart	<ul><li>28 days</li><li>84 days</li></ul>	
□ 0.5 mg capsule		Take 0.5 mg PO one time daily	□ 30 days	
(fingolimod)	□ 0.25 mg capsule	Take 0.25 mg PO one time daily	□ 90 days	
🗆 Kesimpta	20. (0.4. 1	Initial: Inject 20 mg SC every week for 3 weeks (days 1, 8, and 15)	3 doses	0
(ofatumumab)	20 mg/0.4 mL pen	Maintenance: Inject 20 mg SC once monthly starting at week 4	□ 30 days □ 90 days	
Prescriber Informati	on Ship to prescriber:	□ Never □ Always □ First fill only Appointment date:	//	
Name:		DEA# NPI #		
Supervising Physicia	an: $\Box$ Not Applicable $\Box$	Supervising Physician NPI #		
		City: State:		
Office Phone Number	er: ()	Fax Number: () Office Contact:		
I authorize Publix Pl	harmacy representatives to	o act on behalf of the prescriber to initiate and complete the insurance prior a		
D 11		For states requiring		

Prescriber's					to prevent substitution, write here:
signature:					1
(stamps not accepted)	□ Substitution allowed	Date	Dispense as written/ Do not substitute	Date	

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## Publix Specialty Pharmacy #3213 MULTIPLE SCLEROSIS (FORM B)

<b>Patient Information</b>	[Attach copy of	front and back of	f prescription insura	ance card(s)]
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Patient's First Name:	Patient's Last N	ame:	
Date of Birth:/	Caregiver Name	:	
Address:	City:	State:	Zip:
Primary Phone Number: ()	Alt. Phone Num	ıber: ()	
Clinical Information: [Attach copy of labs and clinical notes]	□ Urgent Reques	st Using Cov	er My Meds: 🗆 No 🗆 Yes
Diagnosis code: 🛛 G35 (Multiple Sclerosis) 🔅 Other:		Height: $\Box$ cm $\Box$ in	Weight: $\Box kg \Box lb$
Type: Clinically isolated syndrome (CIS) Clinically isolated syndrome (CIS)	remitting (RRMS)	□ Progressive - relapsing (P	RMS)
□ Primary progressive (PPMS) □ Secondary p	rogressive (SPMS)		
Treatment status: $\Box$ New to therapy $\Box$ Continuation of therap	by, start date:/	/	

Allergies:  $\Box$  NKDA  $\Box$  Other: \_\_\_\_

Prior therapies, reason for discontinuation, treatment dates:

Other pertinent past medical history and/or drug therapy: \_\_\_\_

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
	□ Starter Pack for <b>2 mg</b> dose	Take 0.25 mg PO one time daily on days 1-2, 0.5 mg once on day 3, 0.75 mg once on day 4, and 1.25 mg once on day 5	1 pack (12 tabs)	0
Mayzent (siponimod)	Starter Pack for 1 mg dose	Take 0.25 mg PO one time daily on days 1-2, 0.5 mg once on day 3, and 0.75 mg once on day 4	1 pack (7 tabs)	0
	$\Box$ 2 mg tablet	Take 1 mg PO one time daily beginning on day 6	□ 30 days	
CYP2C9 Genotype:	□ 1 mg tablet	Take 2 mg PO one time daily beginning on day 5	□ 90 days	
□ Ocrevus	200 /10 1 1	Initial: Infuse 300 mg IV on day 1, then infuse 300 mg IV 2 weeks later	2 doses	0
(ocrelizumab)	300 mg/10 mL vial	Maintenance: Infuse 600 mg IV once q 6 months beginning 6 months after first dose	1 dose	
Solu-Medrol (methylprednisolone)	125 mg vial	Give 100 mg IV 30 minutes before each Ocrevus infusion	QS	PRN
□ Zeposia (ozanimod)	□ Starter Pack (0.23 mg, 0.46 mg, & 0.92 mg)	Take 0.23 mg PO one time daily on days 1-4, 0.46 mg one time daily on days 5-7, and 0.92 mg one time daily starting on day 8	1 pack (37 days)	0
(ozaninod)	□ 0.92 mg capsule	Take 0.92 mg PO one time daily	<ul> <li>30 days</li> <li>90 days</li> </ul>	
Prescriber Informatic	Ship to prescriber:	□ Never □ Always □ First fill only Appointment date:	//	
Name:		DEA# NPI #		
		Concentration and Discontinuation NDL #		

Supervising Physician:  Not Applicable		Supervising Physician NPI #		
Address:	City:	State:	Zip:	
Office Phone Number: ()	Fax Number: ()	Office Contact:		

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature:					For states requiring hand written expressions to prevent substitution, write here:
(stamps not accepted)	□ Substitution allowed	Date	Dispense as written/ Do not substitute	Date	

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## Publix Specialty Pharmacy #3213 MULTIPLE SCLEROSIS (FORM C)

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<b>Patient Information</b>	[Attach copy of	front and back of	f prescription insura	ance card(s)]
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Patient's First Name:	_ Patient's Last Na	ame:	
Date of Birth:/	Caregiver Name	:	
Address:	City:	State	: Zip:
Primary Phone Number: ()	Alt. Phone Num	ıber: ()	
Clinical Information: [Attach copy of labs and clinical notes]	□ Urgent Reques	st U	sing Cover My Meds: 🗆 No 🗆 Yes
Diagnosis code: 🛛 G35 (Multiple Sclerosis) 🖓 Other:		Height:	$\square$ cm $\square$ in Weight: $\_\_$ $\square$ kg $\square$ lb
Type: $\Box$ Clinically isolated syndrome (CIS) $\Box$ Relapsing - remit	ting (RRMS)	□ Progressive - rel	apsing (PRMS)
□ Primary progressive (PPMS) □ Secondary progre	ssive (SPMS)		
Treatment status: $\Box$ New to therapy $\Box$ Continuation of therapy, sta	art date:/	/	

Allergies:  $\Box$  NKDA  $\Box$  Other: \_\_\_\_

Prior therapies, reason for discontinuation, treatment dates:

Other pertinent past medical history and/or drug therapy: \_\_\_\_

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
□ 30 mcg/0.5 mL prefilled syringe (PFS)		Titration: Inject 7.5 mcg (0.125 mL) IM on week 1, 15 mcg (0.25 mL) on week 2, 22.5 mcg (0.375 mL) on week 3, then 30 mcg (0.5 mL) on week 4	28 days	0
(interferon $\beta$ -1a)	□ 30 mcg/0.5 mL pen □ 30 mcg/0.5 mL PFS □ 30 mcg vial	Maintenance: Inject 30 mcg IM every week	<ul> <li>28 days</li> <li>84 days</li> </ul>	
<ul> <li>Betaseron (interferon β -1b)</li> <li>0.3 mg vial kit</li> </ul>		Titration: □ Inject 0.0625 mg (0.25 mL) SC every other day on weeks 1 and 2, 0.125 mg (0.5 mL) every other day on weeks 3 and 4, 0.1875 mg (0.75 mL) every other day on weeks 5 and 6, then 0.25 mg (1 mL) every other day on week 7 and thereafter	56 days	0
		Maintenance: Inject 0.25 mg (1 mL) SC every other day		
<ul> <li>Extavia (interferon β -1b)</li> <li>0.3 mg vial kit</li> </ul>		Titration: □ Inject 0.0625 mg (0.25 mL) SC every other day on weeks 1 and 2, 0.125 mg (0.5 mL) every other day on weeks 3 and 4, 0.1875 mg (0.75 mL) every other day on weeks 5 and 6, then 0.25 mg (1 mL) every other day on week 7 and thereafter	60 days	0
		Maintenance: Inject 0.25 mg (1 mL) SC every other day	□ 30 days □ 90 days	
Prescriber Informatio	<b>n</b> Ship to prescriber:	□ Never □ Always □ First fill only Appointment date:	//	
Name:		DEA# NPI #		
Supervising Physician	$\square$ Not Applicable $\square$	Supervising Physician NPI #		
Address:		City: State:	Zip:	
Office Phone Number	:: ()	Fax Number: () Office Contact:		
I authorize Publix Pha	armacy representatives to	act on behalf of the prescriber to initiate and complete the insurance prior a	authorization pr	ocess.

Prescriber's signature:					For states requiring hand written expressions to prevent substitution, write here:
(stamps not accepted)	□ Substitution allowed	Date	Dispense as written/ Do not substitute	Date	

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## Publix Specialty Pharmacy #3213 MULTIPLE SCLEROSIS (FORM D)

<b>Patient Information</b>	[Attach copy of	front and back of	f prescription insura	nce card(s)]
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Patient's First Name:	Patient's Last N	Name:			
Date of Birth:/	Caregiver Nam	e:			
Address:	City:	5	State:	Zip:	
Primary Phone Number: ()	Alt. Phone Nur	Alt. Phone Number: ()			
Clinical Information: [Attach copy of labs and clinical notes]	🗆 Urgent Reque	est	Using Cover My Meds: $\Box$ No $\Box$ Yes		
Diagnosis code: $\Box$ G35 (Multiple Sclerosis) $\Box$ Other:		Height:	$\square$ cm $\square$ in	Weight:	$\Box$ kg $\Box$ lb
Type: $\Box$ Clinically isolated syndrome (CIS) $\Box$ Relapsing - re-	mitting (RRMS)	□ Progressive	- relapsing (PR	RMS)	
□ Primary progressive (PPMS) □ Secondary pro	gressive (SPMS)				
Treatment status:  New to therapy  Continuation of therapy, start date:/					

Allergies: 
NKDA Other:

Prior therapies, reason for discontinuation, treatment dates:

Other pertinent past medical history and/or drug therapy:

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS	
Degridy	<ul> <li>Titration Pack pens (63 mcg &amp; 94 mcg)</li> <li>Titration Pack PFS (63 mcg &amp; 94 mcg)</li> </ul>	Titration: Inject 63 mcg SC on day 1 and 94 mcg on day 15	28 days	0	
<ul> <li>Plegridy (peginterferon β -1a)</li> </ul>	□ 125 mcg/0.5 mL pen □ 125 mcg/0.5 mL PFS	Inject 125 mcg SC every other week starting on day 29	□ 28 days		
	125 mcg/0.5 mL PFS     (intramuscular use only)	OSE/STRENGTH       DRECTIONS       QTV/DAYS         itration Pack pens 33 mcg & 94 mcg)       Titration: Inject 63 mcg SC on day 1 and 94 mcg on day 15       28 days         25 mcg/0.5 mL PFS       Inject 125 mcg SC every other week starting on day 29       28 days         25 mcg/0.5 mL PFS       Inject 125 mcg SC every other week starting on day 29       28 days         25 mcg/0.5 mL PFS       Inject 125 mcg IM every other week starting on day 29       28 days         itration Pack PFS       Inject 125 mcg IM every other week starting on day 29       28 days         itration Pack PFS       Titration to 22 mcg: Inject 4.4 mcg (0.1 mL) SC three times per week on weeks 1 and 2, then inject 11 mcg (0.25 mL) SC three times per week on weeks 3 and 4       28 days         itration Pack PFS       Titration to 44 mcg: Inject 8.8 mcg (0.2 mL) SC three times per week on weeks 1 and 2, then inject 22 mcg (0.5 mL) SC three times per week on weeks 3 and 4       28 days         2 mcg/0.5 mL PFS       Inject 1 dose SC three times per week on weeks 3 and 4       28 days         2 mcg/0.5 mL PFS       Inject 1 dose SC three times per week (on same three days at least 48h apart each week)       28 days         Ship to prescriber:       Never       Always       First fill only       Appointment date://         Mot Applicable			
	□ Titration Pack PFS (8.8 mcg & 22 mcg)	Inject 4.4 mcg (0.1 mL) SC three times per week on weeks 1 and 2, then	28 days	0	
<ul> <li>Rebif</li> <li>(interferon β -1a)</li> </ul>	<ul> <li>Titration Pack pens (8.8 mcg &amp; 22 mcg)</li> <li>Titration Pack PFS (8.8 mcg &amp; 22 mcg)</li> </ul>	Inject 8.8 mcg (0.2 mL) SC three times per week on weeks 1 and 2, then	28 days	0	
	□ 22 mcg/0.5 mL pen □ 22 mcg/0.5 mL PFS		2		
	□ 44 mcg/0.5 mL pen □ 44 mcg/0.5 mL PFS	apart each week)			
Prescriber Informatio	n Ship to prescriber:	■ Never □ Always □ First fill only Appointment date:	//		
Name:		DEA# NPI #			
Office Phone Number	:()	Fax Number: () Office Contact:			
I authorize Publix Pha	armacy representatives to				
Prescriber's signature:		For states requiring l	For states requiring hand written expressions		

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accepted)			1	

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