Publix Specialty Pharmacy #3213

MULTIPLE SCLEROSIS (FORM A)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information: [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: ☐G35 (Multiple Sclerosis) ☐Other: _____ Height: _____ ☐cm☐in Weight: _____ ☐kg☐lb

Type: ☐Clinically isolated syndrome (CIS) ☐Relapsing - remitting (RRMS) ☐Progressive - relapsing (PRMS)
☐Primary progressive (PPMS) ☐Secondary progressive (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
☐Dimethyl fumarate	☐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
	☐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	☐28 days ☐84 days	_____
☐Gilenya (fingolimod)	☐0.5 mg capsule	Take 0.5 mg PO one time daily	☐30 days ☐90 days	_____
	☐0.25 mg capsule	Take 0.25 mg PO one time daily		
☐Kesimpta (ofatumumab)	20 mg/0.4 mL pen	Initial: ☐Inject 20 mg SC every week for 3 weeks (days 1, 8, and 15)	3 doses	0
		Maintenance: ☐Inject 20 mg SC once monthly starting at week 4	☐30 days ☐90 days	_____

Prescriber Information Ship to prescriber: ☐Never ☐Always ☐First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

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: (stamps not accepted) _____ ☐Substitution allowed Date _____ ☐Dispense as written/ Do not substitute Date

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MULTIPLE SCLEROSIS (FORM B)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐ Male ☐ Female Caregiver Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information: [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: ☐ G35 (Multiple Sclerosis) ☐ Other: _____ Height: _____ ☐ cm ☐ in Weight: _____ ☐ kg ☐ lb

Type: ☐ Clinically isolated syndrome (CIS) ☐ Relapsing - remitting (RRMS) ☐ Progressive - relapsing (PRMS)
☐ Primary progressive (PPMS) ☐ Secondary progressive (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
☐ Mayzent (siponimod) CYP2C9 Genotype:_____	☐ Starter Pack for **2 mg** 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
	☐ 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
	☐ 2 mg tablet	Take 1 mg PO one time daily beginning on day 6	☐ 30 days ☐ 90 days	_____
	☐ 1 mg tablet	Take 2 mg PO one time daily beginning on day 5		
☐ Ocrevus (ocrelizumab)	300 mg/10 mL vial	Initial: ☐ Infuse 300 mg IV on day 1, then infuse 300 mg IV 2 weeks later	2 doses	0
		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
	☐ 0.92 mg capsule	Take 0.92 mg PO one time daily	☐ 30 days ☐ 90 days	_____

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable ☐ _____ Supervising Physician NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

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MULTIPLE SCLEROSIS (FORM C)

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Phone: 855-797-8254
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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information: [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: ☐G35 (Multiple Sclerosis) ☐Other: _____ Height: _____ ☐cm☐in Weight: _____ ☐kg☐lb

Type: ☐Clinically isolated syndrome (CIS) ☐Relapsing - remitting (RRMS) ☐Progressive - relapsing (PRMS)
☐Primary progressive (PPMS) ☐Secondary progressive (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
☐ Avonex (interferon β -1a)	☐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
	☐30 mcg/0.5 mL pen ☐30 mcg/0.5 mL PFS ☐30 mcg vial	Maintenance: Inject 30 mcg IM every week	☐ 28 days ☐ 84 days	_____
☐ Betaseron (interferon β -1b)	0.3 mg vial kit	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	☐ 28 days ☐ 84 days	_____
☐ Extavia (interferon β -1b)	0.3 mg vial kit	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 Information Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable☐ _____ Supervising Physician NPI # _____

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Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

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MULTIPLE SCLEROSIS (FORM D)

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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information: [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: ☐G35 (Multiple Sclerosis) ☐Other: _____ Height: _____ ☐cm☐in Weight: _____ ☐kg☐lb

Type: ☐Clinically isolated syndrome (CIS) ☐Relapsing - remitting (RRMS) ☐Progressive - relapsing (PRMS)
☐Primary progressive (PPMS) ☐Secondary progressive (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
☐Plegridy (peginterferon β -1a)	☐Titration Pack pens (63 mcg & 94 mcg) ☐Titration Pack PFS (63 mcg & 94 mcg)	Titration: Inject 63 mcg SC on day 1 and 94 mcg on day 15	28 days	0
	☐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 ☐84 days	_____
	☐125 mcg/0.5 mL PFS (intramuscular use only)	Inject 125 mcg **IM** every other week starting on day 29		
☐Rebif (interferon β -1a)	☐Titration Pack PFS (8.8 mcg & 22 mcg)	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	0
	☐Titration Pack pens (8.8 mcg & 22 mcg) ☐Titration Pack PFS (8.8 mcg & 22 mcg)	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	0
	☐22 mcg/0.5 mL pen ☐22 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 ☐84 days	_____
	☐44 mcg/0.5 mL pen ☐44 mcg/0.5 mL PFS			

Prescriber Information

Ship to prescriber: ☐Never ☐Always ☐First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐Not Applicable☐ _____ Supervising Physician NPI # _____

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