Multiple Sclerosis

Clinical Specialty Infusions, LLC
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Patient Information

Patient name: ____________________ DOB: __________
Sex: ❑ Female ❑ Male SSN: ____________________
Language: __________ Wt: _____ ❑kg ❑lbs Ht: _____ ❑cm ❑in
Address: ______________________________
Apt/Suite: _____ City: __________ State: _____ Zip: _____
Phone: ______________ Alternate: ______________
Caregiver name: ______________ Relation: __________
Local pharmacy: ______________ Phone: __________
Insurance plan: ______________ Plan ID: __________
Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: ______________________________
NPI: ______________________________
Address: ______________________________
Apt/Suite: _____ City: __________ State: _____ Zip: _____
Contact: ______________________________
Phone: ______________ Alternate: ______________
Fax: ______________________________
Email: ______________________________
If shipping to prescriber: ❑ First Fill ❑ Always

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ G35 (Multiple Sclerosis) ❑ ______________________ Diagnosis Date: __________
Type: ❑ Clinically isolated syndrome ❑ Relapsing-remitting ❑ Primary-progressive Secondary-progressive
For Amypra®(dalfampridine): 25-foot timed walking test (T25-FW): __________seconds/minutes; __________seconds/minutes

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: ______________ Concomitant Medications: ______________ Allergies: ❑ NKDA ❑ Other: __________

Self-Injectable

Self-Injectable		Quantity		Refill
❑ **Avonex®** (interferon beta-1a)	❑ Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	❑4 x 30 mcg	PFS	0
	❑ Inject 30 mcg intramuscularly once weekly	❑4 x 30 mcg	❑Pens ❑PFS ❑Vials	_____
❑ **Betaseron®** (interferon beta-1b)	❑ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	❑14 x 0.3 mg	Vials	0
	❑ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	❑14 x 0.3 mg	Vials	0
	❑ Inject 0.25 mg (1 mL) subcut every other day	❑14 x 0.3 mg	Vials	_____
❑ **Copaxone®** (glatiramer acetate)	❑ Inject 20 mg subcut once daily ❑ Inject 40 mg subcut three times per week at least 48 hours apart	❑30 x 20 mg ❑12 x 40 mg	PFS	_____
❑ **Extavia®** (interferon beta-1b)	❑ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	❑15 x 0.3 mg	Vials	0
	❑ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-onward: Inject 0.25 mg (1 mL) subcut every other day.	❑15 x 0.3 mg	Vials	0
	❑ Inject 0.25 mg (1 mL) subcut every other day	❑15 x 0.3 mg	Vials	_____
❑ **Kesimpta (ofatumumab)**	❑ Loading dose: Inject 20mg subcut at weeks 0, 1 and 2 ❑ Inject 20mg subcut starting in week 4 and give monthly thereafter	❑ 3 x 20 mg ❑ 12 x 20 mg	PFS	_____
❑ **Glatopa™** (glatiramer acetate)	❑ Inject 20 mg subcut once daily ❑ Inject 40 mg subcut three times per week at least 48 hours apart	❑30 x 20 mg ❑12 x 40 mg	PFS	_____
❑ **Plegridy®** (peginterferon beta-1a)	❑ Inject 63 mcg subcut on day 1; then inject 94 mcg on day 15	❑1 x 63 mcg 1 x 94 mcg	Pens PFS	0
	❑ Inject 125 mcg subcut on day 29 and every two weeks thereafter	❑2 x 125 mcg	Pens PFS	_____
❑ **Rebif®** (interferon beta-1a)	❑ Week 1-2: Inject 4.4 mcg (0.1 mL) subcut three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subcut three times per week.	❑6 x 8.8 mcg 6 x 22 mcg	PFS	0
	❑ Week 5 and thereafter: Inject 22 mcg subcut three times per week	❑12 x 22 mcg	❑Autoinjectors ❑PFS	_____
	❑ Week 1-2: Inject 8.8 mcg (0.2 mL) subcut three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subcut three times per week.	❑6 x 8.8 mcg 6 x 22 mcg	❑Autoinjectors ❑PFS	0
	❑ Week 5 and thereafter: Inject 22 mcg subcut three times per week	❑12 x 44 mcg	❑Autoinjectors ❑PFS	_____

Specialty Support Therapy

Specialty Support Therapy		Quantity	Refill
❑ **Ampyra®** (dalfampridine)	❑ Take 10 mg by mouth twice a day, approximately 12 hours apart	❑ 60 x 10 mg tablets	_____

By signing this form and utilizing our services, you are authorizing CSI PHARMACY and it's employees to serve as your prior authorization agent when dealing with medical and prescription insurance companies.

______________________________ ______________________________
Prescriber's Signature (no stamps) Date

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