Publix Specialty Pharmacy #3213
MULTIPLE SCLEROSIS (INTERFERON THERAPY)

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

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

Primary Phone Number: (____) _____ Alt. Phone Number (____) _____ Caregiver name: _____

CLINICAL INFORMATION [Attach copy of labs and clinical notes]

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

Type: ☐Clinically isolated syndrome (CIS) ☐Relapsing - remitting (RRMS) ☐Progressive - relapsing (PRMS) Weight: _____ ☐kg ☐lb

☐Primary progressive (PPMS) ☐Secondary progressive (SPMS)

Treatment status: ☐New to therapy ☐Continuation of therapy, start date: ___/___/_____

Prior therapies, reason for discontinuation, treatment dates: _____

Other pertinent past medical history and/or drug therapy: _____

Allergies: ☐ NKDA ☐Other: _____

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, and 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 once a week	☐ 28 days ☐ 56 days	_____
☐ Rebif (interferon β -1a)	☐ PFS Titration Pack (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
	☐ Rebidose Titration Pack (8.8 mcg & 22 mcg) ☐ PFS Titration Pack (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 Rebidose ☐ 22 mcg/0.5 mL PFS ☐ 44 mcg/0.5 mL Rebidose ☐ 44 mcg/0.5 mL PFS	Maintenance: Inject 1 dose SC three times per week (on same three days at least 48h apart each week)	☐ 28 days ☐ 56 days	_____
☐ Betaseron (interferon β -1b) ☐ 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	☐ 56 days (Betaseron) ☐ 60 days (Extavia)	0
		Maintenance: ☐ Inject 0.25 mg (1 mL) SC every other day	☐ 28 days (Betaseron) ☐ 56 days (Betaseron) ☐ 30 days (Extavia) ☐ 90 days (Extavia)	_____
☐ Plegridy (peginterferon β -1a)	☐ Pen Starter Pack (63 mcg & 94 mcg) ☐ PFS Starter Pack (63 mcg & 94 mcg)	Titration: Inject 63 mcg SC on day 1 and 94 mcg on day 15	28 days (2 doses)	0
	☐ 125 mcg/0.5 mL pen ☐ 125 mcg/0.5 mL PFS	Maintenance: Inject 125 mcg SC every 2 weeks starting on day 29	☐ 28 days ☐ 56 days	_____

PRESCRIBER INFORMATION [Ship to prescriber: ☐ Never ☐Always ☐First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐No ☐Yes

Name: _____ DEA# _____ 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

For states requiring hand written expressions to prevent substitution, write here:

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MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/ DAYS	REFILLS
☐ Dimethyl fumarate	☐ Starter Pack (120 mg & 240 mg)	Initial: Take 120 mg PO twice a day for 7 days, then take 240 mg PO twice a day with or without food	30 days	0
	☐240 mg capsule	Maintenance: Take 240 mg PO twice a day with or without food	☐30 days ☐90 days	_____
☐ Gilenya (fingolimod)	0.5 mg capsule	Take 0.5 mg PO once daily with or without food	☐30 days ☐90 days	_____
☐ Copaxone (glatiramer acetate)	☐20 mg/mL PFS	Inject 20 mg SC once daily	☐30 days ☐90 days	_____
☐ Glatopa (glatiramer acetate)	☐40 mg/mL PFS	Inject 40 mg SC three times per week (at least 48h apart)	☐28 days ☐56 days	_____
☐ Kesimpta (ofatumumab)	20 mg/0.4 mL pen	Initial: ☐Inject 20 mg SC once weekly for 3 weeks (days 1, 8, and 15)	28 days (3 doses)	0
		Maintenance: ☐Inject 20 mg SC once monthly starting at week 4	☐30 days ☐90 days	_____
☐ Mayzent (siponimod)	☐0.25 mg tablet	Take 1 mg (4 tablets) PO once daily with or without food	☐28 days ☐56 days	_____
	☐2 mg tablet	Take 2 mg PO once daily with or without food	☐30 days ☐90 days	_____
☐ Other: _____	_____	_____	_____	_____
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