Cosentino's SPECIALTY CARE

MULTIPLE SCLEROSIS SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

❶ PATIENT INFORMATION:

Name: ______________________________
Address: ______________________________
City: ______________ State: ____ Zip: ________
Phone: ______________ Alt. Phone: ______________
Email: ______________________________
DOB: ________ Gender: ❍ M ❍ F Caregiver: ________
Height: ______ Weight: ______ Allergies: ________

❷ PRESCRIBER INFORMATION:

Name: ______________________________
Address: ______________________________
City: ______________ State: ____ Zip: ________
Phone: ______________ Fax: ______________
NPI: ______________ DEA: ______________
Tax I.D.: ______________________________
Office Contact: ______________ Phone: ____________

❸ STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ____________ICD-10: ______________ ❑ Relapsing Remitting ❑ Secondary Progressive ❑ Primary Progressive ❑ Progressive Relapsing
What is the severity of patient's disease? ____________________Pregnancy test________________(+/-) Date:__________
Is the medication being used with another disease-modifying therapy for MS? ❑ Yes ❑ No If yes, which medication(s):__________
Is the patient ineligible for all other therapies due to the severity of their MS? ❑ Yes ❑ No
If Relapse Remitting: Has the patient experienced a first clinical episode? ❑ Yes ❑ No ❑ Attach MRI Results Date: __________
Past Failed Therapies: ______________________________
Does the patient have any contraindication(s) to therapy? ❑ No ❑ Yes If Yes: ______________________________

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

❹ INJECTION TRAINING:
❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

❺ PICK UP OR DELIVERY:
❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

❻ INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ______________________________ Patient's Date of Birth: ____________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ AVONEX®	❑ 30mcg Prefilled Syringe ❑ 30mcg Prefilled Autoinjector	❑ **Titration:** Inject 7.5mcg SC on week 1, 15mcg on week 2, 22.5mcg on week 3, 30mcg on week 4 and every week thereafter	1 titration kit	0
		❑ Inject 30mcg IM every week	1 Pack	
❑ BETASERON®	❑ 0.3mg Lyophilized Powder for Reconstitution	❑ **Titration:** Weeks 1-2: Inject 0.0625mg/0.25ml SC every other day Weeks 3-4: Inject 0.125mg/0.50ml SC every other day Weeks 5-6: Inject 0.1875mg/0.75ml SC every other day Weeks 7 and onward: Inject 0.25mg/1ml SC every other day	1 Kit	
		❑ Inject 0.25mg (1ml) SC every other day		
❑ COPAXONE®	❑ 20mg Prefilled Syringe	❑ Inject 20 mg SC daily	30	
	❑ 40mg Prefilled Syringe	❑ Inject 40mg SC three times per week at least 48 hours apart	12	0
❑ DALFAMPRIDINE ER®	❑ 10mg Tablets	❑ Recommended Dose: Take 1 tablet twice daily (approximately 12 hours apart) with or without food	60	
		❑ Other______________________		
❑ DIMETHYL FUMARATE®	❑ 120 mg DR Capsule	❑ Initial dose: Take one 120 mg capsule by mouth twice daily for week 1	14	
	❑ 240 mg DR Capsule	❑ Maintenance dose: Take one 240 mg capsule by mouth twice daily for every week thereafter	60	
❑ EXTAVIA®	❑ 0.3mg Lyophilized Powder for Reconstitution	❑ **Titration:** Weeks 1-2: 0.0625mg/0.25ml SC every other day Weeks 3-4: 0.125mg/0.50ml SC every other day Weeks 5-6: 0.1875mg/0.75ml SC every other day Weeks 7 and onward: 0.25mg/1ml SC every other day	1 Kit	
		❑ Inject 0.25mg (1ml) SC every other day		
❑ GILENYA®	❑ 0.25mg Capsule ❑ 0.5mg Capsule	❑ (Pediatric Patients) 10 years of age and above weighing <40kg: Take one 0.25mg capsule by mouth once daily with or without food ❑ (Pediatric and Adult Patients) 10 years of age and above weighing >40kg: Take one 0.5mg capsule by mouth once daily with or without food ❑ Other______________________		
❑ GLATOPA®	❑ 20mg Prefilled Syringe	❑ Inject 20mg SC daily	30	
	❑ 40mg Prefilled Syringe	❑ Inject 40mg SC three times per week and at least 48 hours apart.	12	
❑ KESIMPTA®	❑ 20mg/0.4ml Prefilled Pen ❑ 20mg/0.4ml Prefilled Syringe	❑ Induction: Inject 20mg SC on Week 0, 1, and 2	3	0
		❑ Maintenance: Inject 20mg SC on day 29 and every 4 weeks thereafter	1	
❑ PLEGRIDY®	❑ Starter Pack: 63mcg/0.5ml and 94mcg/0.5ml Prefilled Pens ❑ Starter Pack: 63mcg/0.5ml and 94mcg/0.5ml Prefilled Syringes	❑ **Titration:** Day 1: Inject 63mcg (0.5ml) SC Day 15: Inject 94mcg (0.5ml) SC Day 29 and every 14 days thereafter: Inject 125mcg (0.5ml) SC	1 starter pack	0
	❑ 125mcg/0.5ml Prefilled Pens ❑ 125mcg/0.5ml Prefilled Syringes	❑ Inject 125mcg (0.5ml) SC every 14 days ❑ Inject 125mcg (0.5ml) IM every 14 days	2	
❑ REBIF®	❑ Titration Pack Rebidose Autoinjectors ❑ Titration Pack Prefilled Syringes	❑ Titration Pack (six 8.8mcg doses and six 22mcg doses)	1 pack	0
	❑ 22mcg Prefilled Syringe ❑ 44mcg Prefilled Syringe ❑ Rebidose® 22mcg Autoinjector ❑ Rebidose® 44mcg Autoinjector	❑ For 22mcg SC 3 times per week maintenance dose: • Weeks 1 & 2: Inject 4.4mcg 3 times per week • Weeks 3 & 4: Inject 11mcg 3 times per week • Weeks 5 and onward: Inject 22mcg 3 times per week ❑ For 44mcg SC 3 times per week maintenance dose: • Weeks 1 & 2: Inject 8.8mcg 3 times per week • Weeks 3 & 4: Inject 22mcg 3 times per week • Weeks 5 and onward: Inject 44mcg 3 times per week		
❑ ______________	______________	______________________		

PRESCRIBER SIGNATURE:
I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______________________ Date: ________ Signature: ______________________ Date: ________

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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