



SPECIALTY PHARMACY

NEUROLOGY

Lake Mary, FL toll free

toll free fax

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER _____

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Person	

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK**CLINICAL INFORMATION**

Diagnosis Code: ☐ G35 Multiple Sclerosis ☐ Other _____
☐ Relapsing Remitting ☐ Primary Progressive ☐ Secondary Progressive ☐ Progressive Relapsing

Drug Allergies: _____

History:
 • Has the patient been previously treated for this condition? ☐ No ☐ Yes Medication failed _____
 • Is the patient currently on therapy? ☐ No ☐ Yes Medication failed _____
 • Will patient stop taking current therapy before starting new therapy? ☐ Yes ☐ No
 • How long will the patient wait before starting the new therapy? _____
 • Are there other medications patient currently taking? Please list: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Avonex®	30mcg <input type="checkbox"/> PFS <input type="checkbox"/> PEN <input type="checkbox"/> Pwd	<input type="checkbox"/> Inject 30mcg intramuscularly once weekly <input type="checkbox"/> Other dosing: _____	1 kit	11
<input type="checkbox"/> Betaseron®	0.3mg Vial	<input type="checkbox"/> Initial Week 1&2: 0.0625mg (0.25ml), Week 3&4: 0.125mg (0.5ml), Week 5&6: 0.1875mg (0.1875mg (0.75ml), Week 7+: 0.25mg (1ml) SQ every other day <input type="checkbox"/> Maintenance Dose: Inject 0.25mg (1ml) SQ every other day	1 kit 1 kit	None 11
<input type="checkbox"/> Copaxone®	<input type="checkbox"/> 20mg PFS <input type="checkbox"/> 40mg /mL PFS	<input type="checkbox"/> Inject 20mg subcutaneously daily <input type="checkbox"/> Inject 40mg subcutaneously three times a week	1 kit 1 kit	11 11
<input type="checkbox"/> Extavia®	0.3mg Vial	<input type="checkbox"/> Initial Week 1&2: 0.0625mg (0.25ml), Week 3&4: 0.125mg (0.5ml), Week 5&6: 0.1875mg (0.1875mg (0.75ml), Week 7+: 0.25mg (1ml) SQ every other day <input type="checkbox"/> Maintenance Dose: Inject 0.25mg (1ml) SQ every other day	1 kit 1 kit	None 11
<input type="checkbox"/> Gilenya®	0.5mg Capsule	Take 1 capsule PO daily	1 month supply	11
<input type="checkbox"/> Glatopa®	20mg PFS	Inject 20mg SQ daily	1 kit	11
<input type="checkbox"/> PlegriDay®	<input type="checkbox"/> Starter Pack <input type="checkbox"/> PEN <input type="checkbox"/> PFS <input type="checkbox"/> 125mcg PFS <input type="checkbox"/> 125mcg PEN	<input type="checkbox"/> Inject 63mcg SQ on day-1, then 94mcg SQ on day -15, then 125mcg SQ on day-29 <input type="checkbox"/> Inject 125mcg SQ every 14 days	1 kit 1 kit	None 11
<input type="checkbox"/> Rebif®	<input type="checkbox"/> Titration Rebidose <input type="checkbox"/> Titration Pack <input type="checkbox"/> 22mcg/0.5mL Rebidose <input type="checkbox"/> 22mcg/0.5mL PFS <input type="checkbox"/> 44mcg/0.5mL Rebidose <input type="checkbox"/> 44mcg/0.5mL PFS	<input type="checkbox"/> Titration Dose: wk 1&2: inject 8.8mcg SQ TIW; wk 3& 4: inject 22mcg SQ TIW; wk 5+: inject 44mcg SQ TIW <input type="checkbox"/> Maintenance Dose: Inject__ mcg SQ TIW	1 kit 1 kit	None 11
<input type="checkbox"/> Tecfidera®	<input type="checkbox"/> Titration Starter Pack Caps <input type="checkbox"/> 240mg <input type="checkbox"/> 120mg	<input type="checkbox"/> Titration Dose: Take 120mg PO BID x 7 days, then take 240mg PO BID thereafter <input type="checkbox"/> Take 240mg capsule PO Twice Daily <input type="checkbox"/> Take 120mg capsule PO Twice Daily <input type="checkbox"/> Other _____	1 kit 1 month supply 1 month supply	None 11 11
<input type="checkbox"/> Epipen® <input type="checkbox"/> Epipen Jr.®		Inject 1 pen into thigh area in case of anaphylaxis; may repeat	2 pen pack	_____
<input type="checkbox"/> Other _____				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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