For assistance, contact your pharmacy representative: _____ Phone: _____ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

Walgreens | allianceRx Walgreens + PRIME

Multiple Sclerosis

Prescription/Pharmacy Intake Form

☐Central Pharmacy: _____

☐Retail/Community Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____

Insurance provider **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Restart ☐Patient is currently on therapy Start date: _____

Primary Diagnosis Code (ICD-10): _____ Diagnosis: ☐RRMS ☐SPMS ☐PPMS ☐PRMS Date of Diagnosis: _____

Current Weight: _____ Date: _____

Current Therapy: ☐Aubagio ☐Avonex ☐Betaseron ☐Copaxone ☐Extavia ☐Gilenya ☐Glatiramer Acetate ☐Glatopa ☐Lemtrada ☐Novatrone ☐Ocrevus ☐Plegridy ☐Rebif ☐Tecfidera ☐Tysabri

Concomitant Medications: _____ Other Therapies Tried & Failed (Please List): _____

Other Health Conditions: _____

Allergies: _____

MEDICATIONS

☐**Ampyra** 10mg Extended Release Tablets
Directions: _____ Qty: _____ Refills: _____

☐**Aubagio**
☐7mg Tablets ☐14mg Tablets
Directions: _____ Qty: _____ Refills: _____

☐**Avonex 30mcg**
☐Pen ☐Prefilled Syringes ☐Titration Kit
Directions: _____ Qty: _____ Refills: _____

☐**Betaseron**
Directions: _____ Qty: _____ Refills: _____

☐**Copaxone**
☐20mg ☐40mg ☐Prefilled Syringes
Directions: _____ Qty: _____ Refills: _____

☐**Dalfampridine** 10mg Extended Release Tablets
Directions: _____ Qty: _____ Refills: _____

☐**Extavia**
Directions: _____ Qty: _____ Refills: _____

☐**Gilenya** 0.5mg Caps
Directions: _____ Qty: _____ Refills: _____

☐**Glatiramer Acetate**
☐20mg/mL Prefilled Syringes ☐40mg/mL Prefilled Syringes
Directions: _____ Qty: _____ Refills: _____

☐**Glatopa**
☐20mg/mL Prefilled Syringes ☐40mg/mL Prefilled Syringes
Directions: _____ Qty: _____ Refills: _____

☐**Lemtrada**
Contact MS One to One at 855-557-2478 or at 855-676-6326 (fax)

☐**Lioresal IT**
Directions: _____ Qty: _____ Refills: _____

☐**Novantrone**
☐10mg/5mL ☐20mg/10mL
☐Other: _____
Directions: _____ Qty: _____ Refills: _____

☐**Ocrevus** 300mg/10mL Single-Dose Vial
Directions: _____ Qty: _____ Refills: _____

☐**Plegridy**
☐63mcg/94mcg Pen Starter Pack ☐125mcg Pen Maintenance Pack
☐63mcg/94mcg Prefilled Syringe Starter Pack ☐125mcg Prefilled Syringe Maintenance Pack
Directions: _____ Qty: _____ Refills: _____

☐**Rebif**
☐Titration Pack Rebidose ☐22mcg Rebidose Autoinjector ☐44mcg Rebidose Autoinjector
☐Titration Pack ☐22mcg Prefilled Syringes ☐44mcg Prefilled Syringes
Directions: _____ Qty: _____ Refills: _____

☐**Tecfidera**
☐30 Day Starter Pack
☐120mg Capsules ☐240mg Capsules
Directions: _____ Qty: _____ Refills: _____

☐**Tysabri**
Contact Touch (Biogen Idec) at 1-800-456-2255 or at 1-800-840-1278 (fax)

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

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

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.