HARMONS
NEIGHBORHOOD GROCER®
SPECIALTY CARE

MULTIPLE SCLEROSIS SPECIALTY CARE PROGRAM

Phone: **855-476-7227** • Fax: **844-786-9749**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

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

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

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

Date of Diagnosis: _____ ICD-10: _____ ❑ Relapse/Remitting ❑ Progressive

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: ❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

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

Medication	Dosage & Strength	Direction	QTY	Refills
❑ AVONEX®	❑ 30mcg Prefilled Syringe ❑ 30mcg Single Dose Vial ❑ 30mcg Avonex Pen	❑ Inject 30mcg IM once a week ❑ **Titration:** 7.5mcg weekly (over a 4 week period) until target dose is reached which is 30mcg	1 Kit	
❑ BETASERON®	❑ 0.3mg Lyophilized Powder	❑ Inject 0.25mg (1ml) SC every other day ❑ **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	
❑ COPAXONE®	❑ 20mg Prefilled Syringe ❑ 40mg Prefilled Syringe	❑ Inject 20mg SC daily ❑ Inject 40mg SC three times per week ❑ Other_____	1 Kit	
❑ EXTAVIA®	❑ 0.3mg Lyophilized Powder	❑ Inject 0.25mg (1ml) SC every other day ❑ **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	
❑ GILENYA®	❑ 0.5mg Capsule	❑ Take one capsule by mouth once daily ❑ Other_____		
❑ GLATOPA™	❑ 20mg Prefilled Syringe	❑ Inject 20mg SC daily	30	
❑ REBIF®	❑ Titration Pack ❑ 22mcg Prefilled Syringe ❑ 44mcg Prefilled Syringe ❑ Rebidose® 22mcg Autoinjector ❑ Rebidose® 44mcg Autoinjector	❑ Titration Pack Rebidose (six 8.8mcg pre-filled autoinjectors and six 22 mcgpre-filled autoinjectors) ❑ 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	1 Kit	
❑ _____	_____	_____		

5 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

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

8 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.