## **MULTIPLE SCLEROSIS PRESCRIPTION FORM**

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

## Owl Specialty Pharmacy 1010 E. Arrow Hwy., Covina, CA 91724

Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523

www.owlspecialty.com



	Patient Ir	formation	: please pro	vide a cop	y of the pat	tient's insuranc	e card or information				
Patient Name:			DOB:		Gender: □ F □ M HT:		<b>W</b> T:				
Address:			City:		State:	Zip Code:		Phone:			
Insurance: Subscriber			 's name:		ID#:		Group #:				
Allergies: □ NKDA	☐ List allergies:										
				Referral E	xpectatio	ns					
Injection training: □ Please complete by pharmacy staff □ Completed by physician office staff □ Completed by home nurse/manuf program					□ Provide to patient □ Please do not provide □ Completed by physic □ Please do not enroll			n enrollment □ Complete at pharmacy ian office staff			
Clinica	al Diagnosis: please fax	or email re	levant clinic	al notes, la	bs, tests ar	nd previous me	edical history to exped	ite prior au	thorizatio	n	
Diagnosis / ICD-10:				Prior treatment - include name and date of prior treatment:							
Current treatment:				Name and	date of initiat	tion:					
Number of relapses in past year: Last MRI		Last MRI da	ate:		☐ Pregnant or planning pregnancy			Serum Creatinine:			
Medication	Dose / Strength		Directions	s				Quantity		Refills	
☐ Avonex	□ 30 mcg pen #4			Inject IM once weekly					☐ 28 days supply		
☐ Betaseron	inje wee			☐ Dose titration: weeks 1-2 inject 0.0625 mg/0.25 mL SC QOD; weeks 3-4 ☐ 28 days s inject 0.125 mg/0.5 mL SC QOD; weeks 5-6 inject 0.187 mg/0.75 mL SC QOD; weeks 7+ inject 0.25 mg/1 mL SC QOD ☐ Maintenance dose: 0.25 mg/1 mL SC QOD							
☐ Copaxone	☐ 20 mg/mL prefilled syri	□ 20 mg/mL prefilled syringe □ 40 mg/mL prefilled syringe		□ 20 mg/mL SC once daily					☐ 28 days supply		
	☐ 40 mg/mL prefilled syri			□ 40 mg/mL SC three times per week, at least 48 hours apart							
☐ Extavia	lavia □ 0.3 mg vial		☐ Dose titration: weeks 1-2 inject 0.0625 mg/0.25 mL SC QOD; weeks 3-4 inject 0.125 mg/0.5 mL SC QOD; weeks 5-6 inject 0.187 mg/0.75 mL SC QOD; weeks 7+ inject 0.25 mg/1 mL SC QOD					☐ 28 days supply			
				☐ Maintenance dose: 0.25 mg/1 mL SC QOD							
☐ Gilenya	☐ 0.5 mg capsule		☐ Take 0.5 mg capsule PO once daily					☐ 28 days supply			
☐ Rebif ☐ Titration Pack (8.8 mcg/ 22 mcg) ☐ Rebif Redidose ☐ 22 mcg prefilled syringes ☐ 44 mcg prefilled syringes			☐ Dose titration: weeks 1-2: 4.4 mcg SC three times a week; weeks 3-4: 11 mcg ☐ 28 days supply SQ three times a week; weeks 5+: 22 mcg SC three times a week								
			$\Box$ Dose titration: weeks 1-2: 8.8 mcg SC three times a week; weeks 3-4: 22 mcg SQ three times a week; weeks 5+: 44 mcg SC three times a week								
			Maintenance: ☐ Inject 22 mcg/0.5 mL OR ☐ Inject 44 mcg/0.5 mL SQ three times a week, at least 48 hours apart								
☐ Other					<u> </u>						
				Prescribe	r Informati	on					
Prescriber name:				Phone:				Office contact name:			
Prescriber address:				City				Ctata	7:		
Prescriber address:				City:				State:	Zip:		
NPI:		DEA:			Fax and/or	Email:					
Prescriber signature:					Date: DO NOT SUBSTITUTE				JTE		

Important Notice: This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.