**LOVELACE SPECIALTY PHARMACY**

500 Walter St Suite 202B Albuquerque, NM 87102

Ph: (505) 727-4532 Toll Free: (888) 727-4530 Fax: (505) 727-2911

**Patient Information**

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Last Name

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Date of Birth

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City State Zip

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Phone number

**Prescriber Information:**

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Prescriber Name

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Prescriber Address

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City State Zip

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Phone Number

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Fax Number

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NPI#

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DEA#

**Insurance Information (fax copy ofcard)**

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Subscriber Name

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Group #

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ID#

**Prescription**

**Gilenya tablets** (fingolimod)

Dispense \_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_

□ Take 1 tablet by mouth once daily

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rebif Pre-filled Syringe** (interferon beta-1a)

Dispense \_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_

□ Titration Pack (12 syringes=4.2ml)

Directions: Inject 8.8mcg sub-q 3 times weekly

for week 1 and 2, then 22mcg sub-q 3 times weekly for week 3 and 4 then start maintenance dosing

□ 22mcg 3 times weekly for 4 weeks

□ 44mcg 3 times weekly for 4 weeks

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rebif Rebidose Pen** (interferon beta-1a)

Dispense \_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_

□ Titration Pack (12 pens=4.2ml)

Directions: Inject 8.8mcg sub-q 3 times weekly

for week 1 and 2, then 22mcg sub-q 3 times weekly for week 3 and 4 then start maintenance dosing

□ 22mcg 3 times weekly for 4 weeks

□ 44mcg 3 times weekly for 4 weeks

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Copaxone Pre-filled Syringe** (glatiramer)

Dispense \_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_

□ 20mg subcutaneously once daily

□ 40mg subcutaneously 3 times weekly

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Avonex Pre-filled Syringe** (interferon beta-1a)

Dispense \_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_

□ 30mcg subcutaneously once weekly for 4 weeks

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Avonex Pen** (interferon beta-1a)

Dispense \_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_

□ 30mcg subcutaneously once weekly for 4 weeks

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Betaseron Pre-filled Syringe**

(interferon beta-1b)

Dispense \_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_

□ Inject 0.3mg subcutaneously every other day

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Extavia** (interferon beta-1b)

Dispense \_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_

□ Inject 0.25mg subcutaneously every other day

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dispense \_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescriber Signature:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**

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