Multiple Sclerosis Medication Request

aetna®

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:

Home Phone:	Work Phone:	Cell Phone:

Weight:	Height:	Allergies:

B. INSURANCE INFORMATION

Carrier Name: ____________________
Member ID #: ____________________
Group #: ____________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: ____________________
ID#: ____________________
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: (Check one): ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.		
Address:	City:	State:	ZIP:

Phone:	Fax:	DEA #:	NPI #:	Office Contact:

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Medication	Directions	Quantity	Refills
☐ AMPYRA 10mg Tablets	☐ 1 tablet PO every 12 hours ☐ Other:	☐ 1month ☐ 3months	
☐ AUBAGIO Tablets ☐ 14mg ☐ 7mg	☐ 1 tablet PO daily ☐ Other:	☐ 1month ☐ 3months	
☐ AVONEX **Titration** ☐ PFS ☐ Vials ☐ AVONEX **Maintenance** ☐ PFS ☐ Vials ☐ PEN ☐ 25G 1" needle	**Initial dose:** ☐ Inject IM weekly: ¼ dose (7.5mcg) week 1, ½ dose (15mcg) week 2, ¾ dose (22.5mcg) week 3, then full dose (30mcg) week 4 **Maintenance dose:** ☐ 30mcg IM weekly	☐ Initial doses **then:** ☐ 1month ☐ 3months ☐ Other:	
☐ BETASERON 0.3mg Vials ☐ EXTAVIA 0.3mg Vials	**Initial dose:** ☐ Inject SQ every other day: 0.0625mg (0.25ml) Weeks 1 & 2, 0.125mg (0.5ml) Weeks 3 & 4, 0.1875mg (0.75ml) Weeks 5 & 6, 0.25mg (1ml) Week 7+ **Maintenance dose:** ☐ 0.25mg (1ml) SQ every other day	☐ Initial doses **then:** ☐ 1month ☐ 3months ☐ Other:	
☐ COPAXONE 20mg PFS ☐ GLATOPA 20mg PFS ☐ COPAXONE 40mg PFS ☐ GLATIRAMER 40mg PFS	☐ 20mg SQ daily ☐ 40mg SQ three times weekly	☐ 1month ☐ 3months	
☐ GILENYA 0.5mg Capsules	☐ 1 capsule PO daily ☐ Other:	☐ 1month ☐ 3months	
☐ LEMTRADA	Please complete a MS One to One/Lemtrada enrollment form and indicate Aetna Specialty Pharmacy as the preferred pharmacy provider. Please call MS One to One at (855)676-6326 for further information		
☐ OCREVUS 300mg Vial ☐ Premed: ☐ Premed:	**Initial dose:** ☐ Infuse 300mg I.V. on day 1 and day 15 ☐ Other: **Maintenance dose:** ☐ Infuse 600mg I.V every 6 months. ☐ Other: **Premedication:** ☐ Sig:	☐ Initial doses **then:** ☐ 1 dose	
☐ PLEGRIDY **Titration** Kit ☐ PFS **OR** ☐ PEN ☐ PLEGRIDY **Maintenance** Kit ☐ PFS **OR** ☐ PEN	**Initial dose:** ☐ 63 mcg SQ on day 1 and 94 mcg SQ on day 15 ☐ Other: **Maintenance dose:** ☐ 125mcg SQ every 14 days ☐ Other:	☐ Initial doses **then:** ☐ 1month ☐ 3months ☐ Other:	

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.

Prescriber's Signature **(Required by Law):**

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Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: ______________________
ID#: ______________________
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:		Last Name: (Check one): ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	DEA #:	NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Medication	Directions	Quantity	Refills
☐ REBIF **Titration** Kit ☐ PFS ☐ PEN ☐ REBIF 22mcg ☐PFS **OR** ☐Rebidose ☐ REBIF 44mcg ☐PFS **OR** ☐Rebidose	**Initial dose:** ☐ 8.8 mcg SQ 3 times a week for Weeks 1 & 2, then 22 mcg SQ 3 times a week for Weeks 3 & 4 **Maintenance dose:** ☐ 44mcg SQ three times a week ☐ 22mcg SQ three times a week	☐ Initial doses **then:** ☐ 1month ☐ 3months ☐ Other:	
☐ TECFIDERA **Titration** Pack (120mg/240mg) ☐ TECFIDERA **Maintenance** dose ☐ 240mg ☐ 120mg	**Initial dose:** ☐ 120mg PO twice daily x 7 days, then increase to maintenance dose of 240mg twice daily ☐ Other: **Maintenance dose:** ☐ Take 1 capsule PO every 12 hours ☐ Other:	☐ Initial doses **then:** ☐ 1month ☐ 3months ☐ Other:	
☐ TYSABRI	☐ Infuse 300mg I.V. every 4 weeks. ☐ Other: Please complete a MS Touch/Tysabri enrollment form and indicate Aetna Specialty Pharmacy as the preferred pharmacy provider. Please call MS Touch at (800)456-2255 for further information		
Other:			
Other:			

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

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Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.