Spring Creek Pharmacy

NEUROLOGY
Phone: 972-517-7900
Fax: 972-517-0400
280 Legacy Drive #102 Plano,TX 75023

DATE _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFORMATION

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFORMATION

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis Code: ❑ 340.0 Multiple Sclerosis ❑ Other: _____

History:
- Has the patient been previously treated for this condition? ❑ Yes ❑ No Medication failed: _____
- Is the patient currently on therapy? ❑ Yes ❑ No Medication failed: _____
- Will patient stop taking current therapy before starting new therapy? ❑ Yes ❑ No
- How long will the patient wait before starting the new therapy? _____
- Are there other medications patient currently taking? Please list: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Avonex®	❑ 30mcg Prefilled Syringe ❑ 30mcg Vials	❑ Inject 30mcg intramuscularly once weekly ❑ Other dosing: _____	4 Week Supply	_____
❑ Betaseron®	❑ 0.3mg Prefilled Syringe	❑ Initial: Week 1&2: 0.0625mg (0.25ml), Week 3&4: 0.125mg (0.5ml), Week 5&6: 0.1875mg (0.75ml), Week 7+: 0.25mg (1ml) SubQ every other day ❑ Maintenance: Inject 0.25mg (1ml) subcutaneously every other day	4 Week Supply	_____
❑ Copaxone®	❑ 20mg Prefilled Syringe	❑ Inject 20mg subcutaneously oonce every day	4 Week Supply	_____
❑ Extavia®	❑ 0.3mg Kit	❑ Inject 0.25mg subcutaneously every other day	4 Week Supply	_____
❑ Gilenya®	❑ 0.5mg Capsule	❑ Take 1 capsule by mouth daily	4 Week Supply	_____
❑ Rebif®	❑ Titration Pack ❑ 22mcg Prefilled Syringe ❑ 44mcg Prefilled Syringe	❑ Initial: Inject - Week 1&2: 8.8mcg (0.2ml), Week 3&4: 22mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Maintenance: Inject 22mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Maintenance: Inject 44mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Other dosing: _____	4 Week Supply	_____

Prescriber's Signature (no stamps) **If Brand required check ❑ DAW** **Date**

By signing this form and utilizing our services, you are authorizing Blake Pharmacy and it's emplyees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.