Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select BioPlus from your EHR!

NEUROLOGY & MULTIPLESCLEROSIS

Fax: 832-886-4298
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zarinapharmacy.com

PATIENT INFORMATI

Name:		SSN:	DOB:
Address:		City:	State: Zip:
Home Phone:	Cell:	Email:	Gender: ◉ Female ◉ Male

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

PRIOR TREATMENT HISTORY ☐ **AVONEX®** ☐ **BETASERON®** ☐ **COPAXONE®** ☐ **GILENYA®** ☐ **Rebif®** ☐ **Other**_____

MS MEDICATIONS

AVONEX® (interferon beta-1a)* ☐ Enroll in Above MS™ 30 mcg (☐ PFS ☐ Pen) Inject IM once weekly
Qty: 4 **Refills:**

BETASERON® (interferon beta-1b)* ☐ Enroll in BETAPLUS®
☐ **Starting Titration:** 62.5 mcg SUBQ every other day for weeks 1 and 2, 125 mcg SUBQ every other day for weeks 3 and 4, 187.5 mcg SUBQ every other day for weeks 5 and 6, 250 mcg SUBQ every other week for weeks 7 and 8
Qty: 30 days **Refills:** 1
☐ **Maintenance Dosing:** 250 mcg (1 ml) SUBQq every other day ☐ BetaConnect
Qty: 14 **Refills:**

COPAXONE® (glatiramer acetate) ☐ Enroll in Shared Solutions® ☐ Enroll in Mylan ADVOCATE®
☐ 20 mg SUBQ every day ☐ 40 mg SUBQ three times per week
Qty: 28 days **Refills:**

Dalfampradine ☐ 10 mg by mouth every 12 hours
Qty: 60 **Refills:**

EXTAVIA® (interferon beta-1b) ☐ Extavia Go Program®
☐ **Starting Titration:** 62.5 mcg SUBQ every other day for weeks 1 and 2, 125 mcg SUBQ every other day for weeks 3 and 4, 187.5 mcg SUBQ every other day for weeks 5 and 6, 250 mcg SUBQ every other week for weeks 7 and 8
Qty: 30 days **Refills:** 1
☐ **Maintenance Dosing:** 250 mcg (1 ml) SUBQ every other day
Qty: 15 **Refills:**

FINGOLIMOD® (gilenya) ☐ 0.5 mg PO once a day ☐ 0.25 mg PO once a day
Qty: 30 **Refills:**

GILENYA® (fingolimod) ☐ Enroll in Gilenya Go Program® ☐ 0.5 mg PO once a day
Qty: 30 **Refills:**

KESIMPTA®(ofatumumab) ☐ Sensoready® Pen
☐ **Starting Dose:** 20 mg SUBQ administered at week 0, 1, and 2
☐ **Maintenance Dosing:** 20 mg administered monthly starting at week 4
Qty: **Refills:**

MAVENCLAD® (cladribine) 10 mg tablet ☐ Take daily by mouth at intervals of 24 hours

Weight Range (kg)	Number of 10 mg tablets per week												
	Week 1						Week 5						
	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 5	Total Tablets
□ 40 to < 50	1	1	1	1	0	4	1	1	1	1	0	4	8 (80mg)
□ 50 to < 60	1	1	1	1	1	5	1	1	1	1	1	5	10 (100 mg)
□ 60 to < 70	2	1	1	1	1	6	2	1	1	1	1	6	12 (120 mg)
□ 70 to < 80	2	2	1	1	1	7	2	2	1	1	1	7	14 (140 mg)
□ 80 to < 90	2	2	2	1	1	8	2	2	2	1	1	7	15 (150 mg)
□ 90 to < 100	2	2	2	2	1	9	2	2	2	2	1	8	17 (170 mg)
□ 100 < 110	2	2	2	2	2	10	2	2	2	2	2	9	19 (190 mg)
□ 110 and above	2	2	2	2	2	10	2	2	2	2	2	10	20 (200 mg)

# of tablets: **# of cycles:**

MAYZENT® (siponimod) ☐ Please complete Mayzent Prescription Start Form and attach to this referral form.

PLEGRIDY® (peginterferon beta-1a)
Induction: ☐ PFS ☐ Pen
63 mcg SUBQ on day 1, 94 mcg SUBQ on day 15
Qty: 1 pack **Refills:** None
Maintenance: 125 mcg/0.5 ml □ PFS □ Pen
125 mcg SUBQ every 14 days, starting day 29 of therapy
Qty: 2 **Refills:**

PONVORY® (ponesimod) tablets
☐ **Starting Titration:** 2 mg PO day 1 and 2, 3 mg PO day 3 and 4, 4 mg PO day 5 and 6, 5 mg PO day 7, 6 mg PO day 8, 7 mg PO day 9, 8 mg PO day 10, 9 mg PO day 11, 10 mg PO day 12,13 and 14.
Qty: 1 pack **Refills:** None
☐ **Maintenance:** 20 mg PO once daily
Qty: 30 **Refills:**

OCREVUS™ (ocrelizumab)
☐ **Starting Dose:** 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion
☐ **Maintenance:** 600 mg intravenous infusion every 6 months
Qty: **Refills:**

OZOBAX™ (baclofen) 5 mg/ml Oral Solution ☐ Goal Dose: ___ mg/day (should be divided into 3-4 doses)
Directions: Increase dose slowly every 3 days by 5 mg PO 3 times/day up to goal dose

Rebif® (interferon beta-1a) ☐ Enroll in MS LifeLines® ☐ PFS/Rebiject II®* ☐ Rebif Rebidose®
Titration Pack:
☐ Goal Dose 22 mcg: (Full dose therapy beginning week 5) 4.4 mcg/0.1 ml SUBQ three times weekly week 1-2, 11 mcg/0.25 mLSUBQ three times weekly weeks 3-4
☐ Goal Dose 44 mcg: (Full dose therapy beginning week 5) 8.8 mcg/0.1 ml SUBQ three times weekly week 1-2, 22 mcg/0.25 ml three times weekly weeks 3-4
Qty: 1 pack **Refills:** None
Maintenance Dosing: ☐ 44 mcg ☐ 22 mcg SUBQ three times per week
Qty: **Refills:**
***Rebiject** (Will come from MS Lifelines®)

TECFIDERA® (dimethyl fumarate) ☐ 120 mg (14 per bottle 7 day supply) ☐ 240 mg (60 per bottle 30 day supply)
☐ **Starting Dose:** 120 mg twice a day, PO, day 1 through 7
☐ **Maintenance Dosing:** Starting day 8, 240 mg PO twice daily
Qty: **Refills:**

Teriflunomide (generic for **Aubagio®**) ☐ 7 mg PO once daily, with or without food.
Qty: 30 **Refills:**

VUMERITY™ (diroximel fumarate)
☐ **Starting Dose:** Take 1 capsule (231 mg) orally twice daily for 7 days, then increase to 2 capsules (462 mg) twice daily.
Qty: 106 **Refills:** None
☐ **Maintenance Dosing:** Take 2 capsules (462 mg) PO twice a day
Qty: 120 **Refills:**
☐ **Alternate Maintenance Dosing:** Take _____ capsules (_____ mg) PO twice a day
Qty: 120 **Refills:**

ZEPOSIA® (ozanimod)
☐ **7- day titration:** Days 1 to 4: Give 0.23 mg PO once daily. days 5 to 7: Give 0.46 mg PO once daily
Qty: 1 **Refills:** None
☐ **Maintenance Dosing:** Starting day 8, 0.92 mg PO once daily
Qty: 30 **Refills:**

☐ **OTHER**
STRENGTH:

SIG/DIRECTIONS:

REFILLS: **QUANTITY:**

*AVAILABLE IN GENERIC

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.

☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:	
Office Contact:	Email:		
Address:	City:	State:	Zip:
NPI #:	Tax ID #:	Ship To: ☐ Patient	☐ MD Office
Prescriber Signature:	Date:		