



Patient

Prescription

Prescriber

Delivery



Albertsons

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PAVILIONS CARRS S Randalls

SAFEWAY () VONS

ACME

Tom Thumb.

c	Patient Name:		_ DOB:	Email Address:		Sex: M	F
÷Ð –	Address:	City:			State:	Zip:	
nforn	ICD-10 Diagnosis Code: Allergies (please note reaction): Current Medications: (list here or attach a medication list):					Lc	itex

Comorbidities: (list here or attach a list):

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

	MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Information	Avonex (interferon beta-1a)	 AvoStartGrip Titration Kit 30mcg Pen 30mcg Prefilled Syringe 30mcg Single Dose Vial 	 Loading dose: Inject 7.5mcg IM once weekly for one week. Then inject 15mcg IM once weekly for week 2. Then inject 22.5mcg IM once weekly for week 3. Then inject 30mcg IM once weekly and thereafter. Inject 30mcg intramuscularly once a week. 	I titration kit (3 syringes) 4 syringes/ vials/pens	
	Betaseron (interferon	0.3 mg Kit (contains 14 vials)	Loading Dose: Inject 0.0625mg (0.25mL) subcutaneously every other day for weeks 1 and 2, then inject 0.125mg (0.5mL) every other day for weeks 3 and 4, then inject 0.1875mg (0.75mL) every other day for weeks 5 and 6, then inject 0.25mg (1mL) every other day for week 7 and thereafter.		
forn	beta-1b)		Maintenance Dose: Inject 0.25mg (1mL) subcutaneously every other day.	14 vials	
<u>_</u>			Other:		
	Copaxone	Copaxone		30 syringes	
	(glatiramer acetate)	40mg/mL Prefilled Syringe (1 kit = 12 syringes)	Inject 40mg subcutaneously 3 times per week, at least 48 hours apart.	12 syringes	

Treatment History: New to Therapy

Continuation of Therapy

Is patient pregnant, nursing or planning pregnancy? Yes No N/A

Is patient using prescribed therapy in combination with other biologics for MS? \Box Yes \Box No

	Prescriber Name:					
	State License #:		DEA #:		NPI:	
~		son Name:				
2	Group or Hospital:				Phone:	
ati	Fax:		Email Addre	ess:		
2				City:	State:	Zip:
Inform		Product Substitution Pern with state specific prescription req cific requirements could result in ou	uirements such as			Date nguage, etc. Non-
Information	Confidentiality Warning: Tl use of the individual or en dissemination, distribution	Ship to Prescriber/Clinic he information contained in this fo tity to which it is addressed. If the or copying of this communication ly notify sender by telephone, and	resimile message is reader of this mess n of the information	age is not the intended contained herein is str	r ntial information intended recipient, you are hereby r	notified that any disclosure,

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Drecrintion

Prescriber



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tient mation	Patient Name: Phone: Cell Phone:		DOB:	Email Address:		_ Sex: M	F
	Address: ICD-10 Diagnosis Code:	City: Diagnosis:			State:	Zip:	
Pati	Allergies (please note reaction): Current Medications: (list here or attach a medication list): _					L	atex

Comorbidities: (list here or attach a list):

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

	MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
	Extavia	0.3mg Kit (contains 15 vials)	Loading Dose: Inject 0.0625mg (0.25mL) subcutaneously every other day for weeks 1 and 2, then inject 0.125mg (0.5mL) every other day for weeks 3 and 4, then inject 0.1875mg (0.75mL) every other day for weeks 5 and 6, then inject 0.25mg (1mL) every other day for week 7 and thereafter.	30 vials	
	beta-1b)		Maintenance Dose: Inject 0.25mg (1mL) subcutaneously every other day.	15 vials	
			Other:		
tion	Gilenya (fingolimod)	0.5mg Capsule	Take 1 capsule by mouth once daily.	30 capsules	
Information	Glatopa	20mg/mL Prefilled Syringe (1 kit = 30 syringes)	Inject 20mg subcutaneously once daily.	30 syringes	
<u> </u>	(glatiramer acetate)	40mg/mL Prefilled Syringe (1 kit = 12 syringes)	Inject 40mg subcutaneously 3 times per week, at least 48 hours apart.	12 syringes	
	Novantrone	20mg/10mL (10mL) Concentrate	Dilute and administer 12mg/m² via intravenous infusion (over 5 to 15 minutes every 3 months. Body surface aream2 (or m squared)	vials	
	(mitoxantrone)	25mg/12.5mL (12.5mL) Concentrate 30mg/15mL (15mL) Concentrate	Other:		

Treatment History: New to Therapy Continuation of Therapy

Is patient pregnant, nursing or planning pregnancy? Yes No N/A Is patient using prescribed therapy in combination with other biologics for MS? 🗌 Yes 🗌 No Novantrone: Is patient's LVEF less than 50%? Yes No Patient's lifetime (cumulative) Novantrone dose: Please attach the latest copy of CBC with differential.

Prescriber Name: NPI: DFA #: State License #: Additional Contact Person Name: nformation Group or Hospital:_ Phone: Fax: Email Address: Address: City: State: Zip: Prescriber Signature: **Product Substitution Permitted** Dispensed as Written Date The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Noncompliance with state specific requirements could result in outreach to the prescriber. nformatior Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy Date Medication Needed: Delivery Confidentiality Warning: The information contained in this facsimile message is privileged and confidential information intended only for the review and use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication of the information contained herein is strictly prohibited. If you have received this communication in error, please immediately notify sender by telephone, and destroy the original documents.

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_	Patient Name:		DOB:			Sex: M	F
on	Phone: Cell Phone:			Email Address:			
÷=	Address:	City:			State:	Zip:	
p	ICD-10 Diagnosis Code: Allergies (please note reaction): Current Medications: (list here or attach a medication list): _	Diagnosis:					
Ĕ	Allergies (please note reaction):					🗆 L	atex
ē	Current Medications: (list here or attach a medication list): _						
Ē							

Comorbidities: (list here or attach a list):

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

	MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Information	Rebif (interferon beta-1a)	Titration Pack (six 8.8mcg and six 22mcg prefilled syringes)	 Loading Dose (44mcg target): Inject 8.8mcg subcutaneously three times weekly for weeks 1 and 2, then inject 22mcg three times weekly for weeks 3 and 4, then inject 44mcg three times weekly thereafter. Doses should be separated by at least 48 hours. Loading Dose (22mcg target): Inject 4.4mcg subcutaneously three times weekly for weeks 1 and 2, then inject 11mcg three times weekly for weeks 3 and 4, then inject 22mcg three times weekly thereafter. Doses should be separated by at least 48 hours. 	12 syringes	
		44mcg/0.5mL Prefilled Syringe 22mcg/0.5mL Prefilled Syringe	 Maintenance Dose: Inject 44mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. Maintenance Dose: Inject 22mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. Other: 	12 syringes	
	Rebif Rebidose (interferon beta-1a)	Titration Pack (six 8.8mcg and six 22mcg autoinjectors) *for 44mcg target dose only*	Loading Dose (44mcg target): Inject 8.8mcg subcutaneously three times weekly for weeks 1 and 2, then inject 22mcg three times weekly for weeks 3 and 4, then inject 44mcg three times weekly thereafter. Doses should be separated by at least 48 hours.	12 syringes	
		44mcg/0.5mL Autoinjector 22mcg/0.5mL Autoinjector	 Maintenance Dose: Inject 44mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. Maintenance Dose: Inject 22mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. Other: 	12 syringes/ autoinjectors	

Treatment History: New to Therapy

Continuation of Therapy

Is patient pregnant, nursing or planning pregnancy? Yes No N/A

Is patient using prescribed therapy in combination with other biologics for MS? Yes No

	Prescriber Name:					
	State License #:		DEA #:		NPI:	
~	Additional Contact P	erson Name:				
Ъ	Group or Hospital:				Phone:	
Ξ	Fax:		Email Addre	ess:		
2	Address:			City:	State:	Zip:
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	ICD-10 Diagnosis Code: Allergies (please note reaction): Current Medications: (list here or attach o	a medication list):	Didgi iosis				[Lc	atex
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Comorbidities: (list here or attach a list):

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MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Tysabri (natalizumab)	300mg/15mL Concentrate	Administer 300mg via intravenous infusion over 1 hour every 4 weeks.	1 vial	
Other Medication Name:				

Treatment History: New to Therapy

Continuation of Therapy

Is patient pregnant, nursing or planning pregnancy? Yes No N/A

Is patient using prescribed therapy in combination with other biologics for MS? Yes No

Prescriber Name:

	State License #:		DEA #:		NPI:	
6	Additional Contact Per	son Name:				
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atio	Fax:		Email Addre	ess:		
scri rmo	Address:			City:	State:	Zip:
Pres Inforr		Product Substitution F y with state specific prescription	requirements such as a			Date
	compliance with state sp	ecific requirements could result i	in outreach to the presc	riber.		
∍ry ation	Ship to Patient	Ship to Prescriber/Clinic	Pick up at Albe	rtsons Companies Pharmac	y Date Medicat	ion Needed:
Deliver Informati	use of the individual or er dissemination, distributio	The information contained in th htity to which it is addressed. If n or copying of this communic ely notify sender by telephone,	the reader of this mess ation of the informatior	age is not the intended recipient contained herein is strictly pro	nt, you are hereby	notified that any disclosure,

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