



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____

Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____

Address _____ City _____ State _____ ZIP _____

Cell phone _____ Other phone _____ Email _____

Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____

Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____

Practice _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Office contact _____

Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Diagnosis: multiple sclerosis ICD-10 G35 Date diagnosed _____

Type ☐ Relapsing-remitting ☐ Active secondary progressive ☐ Clinically isolated syndrome ☐ Primary progressive

Last relapse _____ Latest MRI _____ EDSS score _____

Done before starting ☐ CBC and liver tests ☐ Varicella immunity ☐ ECG ☐ Eye exam ☐ Pregnancy test

Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____

Reason for switching _____

Current medications ☐ List attached _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy

Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

☐ New start: also dispense the starter (titration) doses in each checked drug's label

Medication	Strength	Directions	Quantity	Refills
Injections				
☐ Avonex interferon beta-1a	30 mcg/0.5 mL pen	Inject 30 mcg into the muscle once weekly	4 pens	_____
☐ Rebif Rebidose interferon beta-1a	44 mcg/0.5 mL pen	Inject 44 mcg subcut three times a week	12 pens	_____
☐ Betaseron interferon beta-1b	0.3 mg vial	Inject 0.25 mg subcut every other day	1-month supply	_____
☐ Copaxone or glatiramer glatiramer acetate, brand or generic	40 mg/mL syringe	Inject 40 mg subcut 3 times a week, 48 hours apart	12 syringes	_____
☐ Copaxone or glatiramer glatiramer acetate, brand or generic	20 mg/mL syringe	Inject 20 mg subcut once daily	30 syringes	_____

Tablets and capsules

☐ Dimethyl fumarate Tecfidera generic	240 mg capsule	Take 1 capsule by mouth twice daily	60 capsules	_____
☐ Teriflunomide Aubagio generic	7 mg or 14 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
☐ Fingolimod Gilenya generic; first dose needs monitoring	0.5 mg capsule	Take 1 capsule by mouth once daily	30 capsules	_____
☐ Zeposia ozanimod, 7-day starter pack first	0.92 mg capsule	Take 1 capsule by mouth once daily	30 capsules	_____
☐ Dalfampridine ER Ampyra generic, for walking	10 mg tablet	Take 1 tablet by mouth every 12 hours	60 tablets	_____

Other medication (write in)

☐ _____

☐ _____

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.