

# CHS SPECIALTY PHARMACY SERVICE PRESCRIPTION ORDER FORM

**Phone:** 704-512-6057

**Fax** 704-512-6058

**PHARMACY HOURS: 8:30am – 5pm Monday thru Friday**



Carolinus HealthCare System

**Provider Name:** \_\_\_\_\_ **Office contact name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_  
**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Sex:**  Male  Female **ICD-9 Code:** \_\_\_\_\_  
**Date of birth:** \_\_\_/\_\_\_/\_\_\_ **Social Security #** XXX XX \_\_\_ \_\_\_ \_\_\_ **Diagnosis:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Deliver to:**  Provider Office  Patient  
**City:** \_\_\_\_\_ **Needs by:** \_\_\_\_\_  
**State:** \_\_\_ **Zip Code:** \_\_\_\_\_ **Best Contact number:** \_\_\_\_\_

**Other Clinical Information:** Patient's Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs = \_\_\_\_\_ Kg BSA: \_\_\_\_\_ m<sup>2</sup>

**Prescription Insurance Name:** \_\_\_\_\_ **Pharmacy Help Desk Phone Number:** \_\_\_\_\_

**\*Please send a copy of the front and back of patients insurance card(s)**

Medications	Dosing & Frequency	Quantity	Refills
<input type="checkbox"/> Avonex ®	<input type="checkbox"/> 30 mcg per syringe <input type="checkbox"/> Inject IM weekly <input type="checkbox"/> _____	4 unit admin pack (28 day)	
<input type="checkbox"/> Betaseron ®	<input type="checkbox"/> 0.25 mg vial <input type="checkbox"/> Inject SQ every other day <input type="checkbox"/> _____	14 unit blister pack (28 day)	
<input type="checkbox"/> Copaxone ®	<input type="checkbox"/> 0.20 mg per syringe <input type="checkbox"/> Inject SQ daily <input type="checkbox"/> _____	30 unit pre-filled syringes (30 day)	
<input type="checkbox"/> Extavia ®	<input type="checkbox"/> 0.25 mg vial <input type="checkbox"/> Inject SQ every other day <input type="checkbox"/> _____	15 unit blister pack (30 day)	
<input type="checkbox"/> Rebif ®	<input type="checkbox"/> 8.8 mcg per syringe 22.0 mcg per syringe <input type="checkbox"/> 22.0 mcg per syringe <input type="checkbox"/> 44.0 mcg per syringe <input type="checkbox"/> Inject SQ three times per week <input type="checkbox"/> _____	<input type="checkbox"/> Titration pack 6 - 8.8 mcg syringes 6 - 22.0 mcg syringes (28 day) <input type="checkbox"/> 12 - 22.0 mcg syringes (28 day) <input type="checkbox"/> 12 - 44.0mcg syringes (28 day)	
<input type="checkbox"/> _____			

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