Multiple Sclerosis Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ DOB: _____

Alternate Phone: _____ Gender: ☐ Male ☐ Female

Last 4 digits of SS#: _____

Email: _____

PRESCRIBER INFORMATION

Name: _____

State License #: _____ NPI #: _____

DEA #: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form (front and back).

PRESCRIPTION

Diagnosis and Clinical Information

Date of Diagnosis: _____/_____/_____

☐ G35 Multiple Sclerosis

☐ C81.18 Nodular sclerosis classical Hodgkin lymphoma, lymph nodes of multiple sites

Other: _____

Type:

☐ Relapse-remitting ☐ Primary-progressive

☐ Secondary-progressive ☐ Progressive-relapsing

Is this patient nursing or planning pregnancy?

☐ Yes ☐ No

Number of relapses in the past year: _____

Date of last MRI: _____

Were there any changes with the latest MRI? ☐ Yes ☐ No

Allergies: _____

☐ **Avonex®**	30mcg Prefilled Syringe #4 30mcg Pen #4	Inject 30mcg IM once weekly	4 week supply	
☐ **Betaseron®**	0.3mg vial	**Dose Titration:** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD **Maintenance Dose:** 0.25mg /1ml subcutaneously QOD **Other:**	4 week supply	
☐ **Copaxone®**	20mg Prefiled Syringe	20mg SQ QD	4 week supply	
☐ **Extavia®**	0.3mg vial	**Maintenance Dose:** 0.25mg /1ml subcutaneously QOD **Dose Titration:** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD **Other:**	4 week supply	
☐ **Gilenya®**	0.5mg capsule	Take 0.5mg po QD	4 week supply	
☐ **Rebif®** ☐ **Rebif Redidose**	Titration Pack (8.8mcg/22mcg) 22mcg Prefilled Syringe 44mcg Prefilled Syringe	Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) **Maintenance:** Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) **Maintenance:** Inject 44mcg (0.5ml) SQ three times a week (48 hours apart)	4 week supply	
☐ **Mitoxantrone®**	12mg/m2 IV	Every 3 months up to a total lifetime dose of 140mg/m2		

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: **Date**: