Multiple Sclerosis Enrollment Form

Specialty Pharmacy Fax: **1-781-805-8245**
Specialty Pharmacy Phone: **1-844-319-7588**

① PATIENT INFORMATION

Patient Name			Date of Birth
Address			**Primary Phone**
City	**State**		**Alternate Phone**
Zip Code	**Gender**		**Email**
	Male	Female	
Primary Language			

② PRESCRIBER INFORMATION

Prescriber's Name	License #
DEA #	**NPI #**
Group or Hospital Name	**Contact Person**
Address	**Phone**
City, State, Zip Code	**Fax**

③ INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with applicable pre-authorization approvals with this form, if available.

④ MEDICAL INFORMATION

Diagnosis – Please include diagnosis name with ICD-10 code
☐ G35 Multiple sclerosis (MS)
☐ Other diagnosis: ICD-10 code: ___________________________
Description: ___________________________
Date of diagnosis: ___________________________
Please indicate type:
☐ Primary progressive MS (PPMS)
☐ Relapsing-remitting MS (RRMS)
☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS) – Documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS – MRI features consistent with MS? ☐ Yes ☐ No

⑤ ADDITIONAL INFORMATION

Ship to: ☐ Patient ☐ MD office ☐ Infusion clinic
Therapy: ☐ New ☐ Refill ☐ Restart
Weight: ________ kg/lb Height: _________ cm/in
Allergies: ___________________________
Previous therapy: ___________________________
Reason for failed therapy: ___________________________
Patient is interested in patient support programs? ☐ Yes ☐ No
Injection training needed? ☐ Yes ☐ No
Need by date: ___________________________

⑥ PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Aubagio®	☐ 7mg ☐ 14mg	☐ Take 1 tablet PO once daily Enroll in MS 1:1? ☐ Yes ☐ No		
☐ Avonex®	☐ 30mcg pen ☐ 30mcg prefilled syringe ☐ 30mcg single dose vial	☐ Inject 30mcg IM once a week ☐ Inject 7.5mcg IM on week 1, then increase dose by 7.5mcg each week until 30mcg once weekly is reached		
☐ Betaseron®	☐ 0.3mg	☐ Initial: Inject 0.0625mg SC every other day, increase every 2 weeks by 0.0625mg to recommended dose of 0.25mg every other day ☐ Maintenance: Inject 0.25 mg SC every other day		
☐ Copaxone® ☐ Glatopa® PFS ☐ Glatiramer acetate	☐ 20mg prefilled syringe ☐ 40mg prefilled syringe	☐ Inject 20mg SC once daily ☐ Inject 40mg SC 3 times a week		
☐ Gilenya®	☐ 0.5mg	☐ Take 1 capsule PO once daily ***QTc Interval: _______ ms ***Date of 1st dose observation: ___________________		
☐ Ocrevus®	☐ 300mg/10ml single dose vial	☐ Initial: Infuse 300mg IV on day 1, followed by 300mg 2 weeks later ☐ Maintenance: Infuse 600mg IV every 6 months, due 6 months after 1st dose		
☐ Plegridy®	☐ Pen Starter Pack ☐ Syringe Starter Pack	☐ Inject 63mcg SC on day 1, then 94mcg on day 15, then 125mcg every 14 days thereafter		
	☐ Pen Maintenance Pack ☐ Syringe Maintenance Pack	☐ Inject 125mcg SC every 14 days		
☐ Rebif®	☐ Syringe Titration Pack ☐ Rebidose Titration Pack	☐ Titration to 22mcg: Inject 4.4mcg SC 3 times a week on weeks 1 and 2, then 11mcg 3 times a week on weeks 3 and 4, then 22mcg 3 times a week thereafter ☐ Titration to 44mcg: Inject 8.8mcg SC 3 times a week on weeks 1 and 2, then 22mcg 3 times a week on weeks 3 and 4, then 44mcg 3 times a week thereafter		
	☐ 22mcg syringe ☐ 44mcg syringe ☐ Rebidose 22mcg autoinjector ☐ Rebidose 44mcg autoinjector	☐ Inject 22mcg SC 3 times a week ☐ Inject 44mcg SC 3 times a week		
☐ Tecfidera®	☐ Starter Pack ☐ 120mg ☐ 240mg	☐ Initial: Take 120mg PO twice daily for 7 days, then 240mg twice daily thereafter ☐ Maintenance: Take 240mg PO twice daily		

*Ancillary supplies provided as needed for administration

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X ___________________________ X ___________________________
SUBSTITUTION ALLOWED (Date) DISPENSE AS WRITTEN (Date)

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