

Multiple Sclerosis Enrollment Form

Fax to: 817-332-5363

PHARMACY LOCATION
Phone: 817-335-5712
Fax: 817-332-5363
800 8th Avenue, Suite 130
Fort Worth, TX 76104



DATE: _____ SHIP TO:
DATE NEEDED: _____ PATIENT OFFICE

PATIENT INFO
NAME _____ E-MAIL _____ DOB _____ MALE FEMALE
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

INSURANCE INFORMATION Please Fax Copy Of Insurance Card (Front & Back) Also Fax Clinical Notes, Labs, and Test with Referral Form
DIAGNOSIS Date of Diagnosis: _____ G35. Multiple Sclerosis Other: _____ Height: _____ Weight: _____ kg
Type: Relapsing-remitting Primary progressive Secondary Progressive Progressive-Remitting Allergies _____ NKDA
Other medications patient is currently taking, including OTCs, with dose & directions (or fax medication profile: _____
Has patient been treated previously for this condition? Yes No Medication(s) failed: _____
Is patient currently on therapy? Yes No - Type/medication: _____
Will patient stop taking above medication(s) before starting the new medication? Yes No If yes, how long should patient wait before starting the new medication? _____
Date of last MRI: _____ Changes? Yes No Number of relapses in the past year: _____ Is patient pregnant or breastfeeding? Yes No

CLINICAL INFORMATION
PRESCRIPTION INFORMATION
GLATIRAMER
 Zeposia
INITIAL DOSE:
 Starter Kit (0.23/0.46 capsule)
 Starter Kit: Days 1-4: Take 0.23mg by mouth once daily. Days 5-7: Take 0.46mg by mouth once daily.
QTY: 1 Kit (7 capsules) Refills: _____
MAINTENANCE DOSE:
 0.92mg capsule
 Days 8 and thereafter: Take 1 capsule (0.92mg) by mouth once daily.
QTY: 30 capsules Refills: _____
 Copaxone®
 20mg/mL Prefilled Syringe
 40mg/mL Prefilled Syringe
 Inject 20mg SC daily
 Inject 40mg SC three times per week
 Other _____
QTY: 1 kit/ 30 syringes
 1 kit/ 12 syringes
 Other _____ Refills: _____
 Glatopa™
 20mg/ml Prefilled Syringe
 40mg/ml Prefilled Syringe
 Inject 20mg SC daily
 Inject 40mg SC 3 times per week
 Other _____
QTY: 1 kit/ 30 syringes
 1 kit/ 12 syringes
 Other _____ Refills: _____
 Gilenya® (fingolimod)
 0.5mg capsules
 Take 1 capsule by mouth daily
 Other _____
QTY: 30 capsules
 Other _____ Refills: _____
 Dalfampridine
 10mg ER tablet
 Take 1 tablet (10mg) by mouth every 12 hours with or without food.
QTY: 60 tablets Refills: _____
 Other: _____
 Dose: _____
 Instruction: _____
QTY: _____ Refills: _____
INTERFERON BETA 1A
 Avonex®
 30mcg/0.5ml Pen
 30mcg/0.5ml Prefilled Syringe
 Inject 30mcg IM weekly Other _____
QTY: 4 Other _____ Refills: _____
 Rebif®
 Rebif® Prefilled Syringes
 Rebif Rebidose® Autoinjector Pens
 22 mcg/0.5ml 44 mcg/0.5ml
INITIAL TITRATION DOSE:
 Titration Pack _____ (8.8mcg/22mcg Prefilled Syringes)
 Titration Pack _____ (8.8mcg/22mcg Autoinjector Pens)
 Inject 4.4 mcg SC three times per week on weeks 1-2, then 11 mcg SC three times per week on weeks 3-4, then maintenance dosing.
 Inject 8.8mcg SC three times per week on weeks 1-2, then 22mcg SC three times per week on weeks 3-4, then maintenance dosing.
 Other _____
QTY: 4 week supply (12 syringes)
 Other _____ Refills: _____
MAINTENANCE DOSE:
 22mcg/0.5ml Prefilled Syringes
 44mcg/0.5ml Prefilled Syringes
 22mcg/0.5ml Autoinjector Pens
 44mcg/0.5ml Autoinjector Pens
 Inject 22mcg SC three times per week (48 hrs apart).
 Inject 44mcg SC three times per week (48 hrs apart).
 Other _____
QTY: _____ Refills: _____
 Plegridy
 Subcutaneous Pen Starter Pack Rx (first month)*
 Maintenance Rx (months 2-13)
INITIAL DOSE: Inject 63mcg day 1 and 94mcg day 15. Inject 125mg day 29 and every 14 days thereafter
MAINTENANCE DOSE: Inject 125mcg every 14 days
QTY: Starter Kit #1 kit/2 syringes
 Maintenance Kit #1 kit/2 syringes
 Other _____ Refills: _____
INTERFERON BETA 1B
 Betaseron®
INITIAL TITRATION DOSE: 0.3mg vial
 Week 1-2: Inject 0.0625mg/0.25ml SC every other day
 Week 3-4: Inject 0.125mg/0.5ml SC every other day
 Week 5-6: Inject 0.1875mg/0.75ml SC every other day
 Week 7+: Inject 0.25mg/1ml SC every other day
 Other _____
QTY: 28 Day Supply (1 Kit / 14 Vials)
 Other _____ Refills: _____
MAINTENANCE DOSE:
 0.3mg vial
 Inject 0.25mg/1ml SC every other day
 Other _____
QTY: 28 Day Supply (1 Kit / 14 Vials)
 Other _____ Refills: _____
 Extavia®
INITIAL TITRATION DOSE: 0.3mg vial
 Week 1-2: Inject 0.0625mg/0.25ml SC every other day
 Week 3-4: Inject 0.125mg/0.5ml SC every other day
 Week 5-6: Inject 0.1875mg/0.75ml SC every other day
 Week 7+: Inject 0.25mg/1ml SC every other day
 Other _____
QTY: 4 week supply
 Other _____ Refills: _____
MAINTENANCE DOSE: 0.3mg vial
 Inject 0.25mg/1ml SC every other day
 Other _____
QTY: 4 week supply
 Other _____ Refills: _____
 Dimethyl Fumarate (Tecfidera)
 30-day starter pack 120 mg capsules
 240 mg capsules
INITIAL DOSE:
 Take 120 mg PO BID x 7 days + 240 mg PO BID x 23 days
MAINTENANCE DOSE:
 Take 120 mg PO BID
 Take 240 mg PO BID
 Other _____
QTY: 56 capsules 60 capsules
 Other _____ Refills: _____

NOTES / OTHER

INJECTION TRAINING Patient has received injection training Physician Office to provide injection training Pharmacy to provide injection training

PRESCRIBER INFORMATION
Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI #: _____ DEA #: _____ TAX ID #: _____ Medicaid Provider #: _____
PRESCRIBER'S SIGNATURE _____ (DATE) _____ *IF BRAND DRUGS ARE PREFERRED, HANDWRITE "BRAND MEDICALLY NECESSARY" ABOVE
I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.