Multiple Sclerosis Enrollment Form (A-E)

PATIENT INFORMATION

Patient Name: ____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: ____
City: ____________________ State: ________ Zip: _______________

Phone: (_____) - _____ - ________
Email: ____
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: ______________________________ ID#: _________________________ Group #: _______________ RxBIN: ____________ RxPCN: ____________

PRESCRIBER INFORMATION

Prescriber Name: ____
Address: ____
City: ____________________ State: ________ Zip: _______________
Contact: _______________ Clinic/Hospital Affiliation: _______________

Phone: (_____) - _____ - ________ Fax: (_____) - _____ - ________
License #: ____
NPI #: ____
Medicaid Provider #: ____

MSAERX-19-01

CLINICAL CONSIDERATIONS

Diagnosis: ☐ G35 Multiple Sclerosis
☐ Other ICD10: ______________
Subtype of Multiple Sclerosis:
☐ Clinically isolated syndrome ☐ Secondary progressive
☐ Relapsing-remitting ☐ Primary progressive
Date of last MRI: ________________ MRI changes: ☐ Yes ☐ No
Number of relapses in the past year: ______________________________

Please include a copy of relevant labs with dates (i.e. CBC, LFTs, bilirubin, TSH, etc.)

Please list previously tried/failed therapies & dates:

Immunization History
☐ Influenza
Date: ____ /____ / ____

Pregnancy Test:
☐ Positive ☐ Negative
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Avonex**® (interferon beta-1a)	☐ 30 mcg pen ☐ 30 mcg prefilled syringe	☐ **Initial:** Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly		
		☐ **Maintenance:** Inject 30 mcg intramuscularly once weekly		
☐ **Betaseron**® (interferon beta-1b)	☐ 0.3 mg prefilled syringe	☐ **Initial**: Weeks 1-2: Inject 0.0625 mg (0.25 mL) subcutaneously every other day Weeks 3-4: Inject 0.125 mg (0.5 mL) subcutaneously every other day Weeks 5-6: Inject 0.1875 mg (0.75 mL) subcutaneously every other day Weeks 7+: Inject 0.25 mg (1 mL) subcutaneously every other day		
		☐ **Maintenance**: Inject 0.25 mg (1 mL) subcutaneously every other day		
☐ **Copaxone**® (glatiramer acetate)	☐ 20 mg prefilled syringe ☐ 40 mg prefilled syringe	☐ Inject 20 mg subcutaneously once daily ☐ Inject 40 mg subcutaneously three times per week at least 48 hours apart		
☐ **Extavia**® (interferon beta-1b)	☐ 0.3 mg vial kit	☐ **Initial**: Weeks 1-2: Inject 0.0625 mg (0.25 mL) subcutaneously every other day Weeks 3-4: Inject 0.125 mg (0.5 mL) subcutaneously every other day Weeks 5-6: Inject 0.1875 mg (0.75 mL) subcutaneously every other day Weeks 7+: Inject 0.25 mg (1 mL) subcutaneously every other day		
		☐ **Maintenance**: Inject 0.25 mg (1 mL) subcutaneously every other day		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: ____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: ________________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: _____ / _____ / _____

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