Multiple Sclerosis Enrollment Form (F-Z)

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 #: ____

MSFZRX-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
☐ **Gilenya®** (fingolimod)	☐ 0.5 mg capsule	☐ Take one capsule by mouth once daily		
☐ **Glatopa®** (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		
☐ **Rebif®** (interferon beta-1a)	**Initial**: ☐ Titration Pack prefilled syringe (six 8.8 mcg and six 22 mcg injections) ☐ Titration Pack Rebidose® autoinjector (six 8.8 mcg and six 22 mcg injections)	☐ **Target dose 22 mcg three times a week** Weeks 1-2: Inject 4.4 mcg (0.1 mL) subcutaneously three times a week Weeks 3-4: Inject 11 mcg (0.25 mL) subcutaneously three times a week, then maintenance dose ☐ **Target dose 44 mcg three times a week** Weeks 1-2: Inject 8.8 mcg (0.2 mL) subcutaneously three times a week Weeks 3-4: Inject 22 mcg (0.5 mL) subcutaneously three times a week, then maintenance dose	28-day supply (1 kit)	0
	Maintenance: ☐ 22 mcg prefilled syringe ☐ 22 mcg Rebidose® autoinjector ☐ 44 mcg prefilled syringe ☐ 44 mcg Rebidose® autoinjector	☐ Inject 22 mcg subcutaneously three times a week ☐ Inject 44 mcg subcutaneously three times a week		

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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