Multiple Sclerosis Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: ______________ Ship To: ☐ Home ☐ Office ☐ Other: ______________

PATIENT INFORMATION

Patient Name: ______________
Address: ______________
City, State, Zip: ______________
Home Phone: ______________
Cell Phone: ______________
Date of Birth: ______________ Gender: ______________
Emergency Contact: ______________ Phone: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________
Address: ______________
City, State, Zip: ______________
Phone: ______________
Fax: ______________
DEA #: ______________ NPI #: ______________
Contact Person: ______________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______________ ID: ______________ Group: ______________
Secondary Insurance: ______________ ID: ______________ Group: ______________
Prescription Card: ______________ ID: ______________ BIN: ______________ PCN: ______________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS/CLINICAL INFORMATION

Multiple Sclerosis:

☐ G35 Multiple Sclerosis
☐ G35 Relapsing/Remitting
☐ G35 Primary Progressive
☐ G35 Secondary Progressive
☐ Other: ______________

Number of Relapses the past year: ______________
Date of Diagnosis: ______________
Date of last MRI: ______________ MRI Changes: ☐ Yes ☐ No

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Prior Treatment: ☐ Avonex® ☐ Copaxone® ☐ Rebif® ☐ Betaseron® ☐ Extavia® ☐ Other: ______________

Treatment Response: ______________ Treatment Dates: ______________
Patient Weight: ______ ☐ kg ☐ lbs Height: ______ ☐ cm ☐ in
Allergies: ______________
Lab Data: ______________
Concomitant Medications: ______________
Comorbidities: ______________

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Avonex® (Biogen Idec)	☐ 30mcg Syringe ☐ 30mcg Pen ☐ 30mcg Vial			
☐ Betaseron® (Bayer)	☐ 0.3mg Vial & Diluent			
☐ Copaxone® (Teva)	☐ 20mg Syringe ☐ 40mg Syringe			
☐ Extavia® (Novartis)	☐ 0.3mg Vial & Diluent			
☐ Gilenya® (Novartis)	☐ 0.5mg Capsule			
☐ Glatopa® (Sandoz)	☐ 20mg per 1mL Syringe			
☐ Rebif® (EMD Serono)	☐ Titration Pack ☐ Rebidose® AutoInjector Titration			
	☐ 22mcg Syringe ☐ Rebidose® AutoInjector 22mcg			
	☐ 44mcg Syringe ☐ Rebidose® AutoInjector 44mcg			

ADDITIONAL COMMENTS:

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X ______________ X ______________

PRODUCT SUBSTITUTION PERMITTED (Date) **DISPENSE AS WRITTEN** (Date)

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