



# Multiple Sclerosis Enrollment Form

Fax: 909-284-9140 Phone: 909-266-0016

Urgent Request

Rep: \_\_\_\_\_

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Last Four of SS \_\_\_\_\_ Gender \_\_\_\_\_  
 Language Preference \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name \_\_\_\_\_  
 DEA \_\_\_\_\_  
 NPI \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Contact Person \_\_\_\_\_

### Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

**Diagnosis** - Please include diagnosis name with ICD-10 code

Additional information | Therapy  New  Reauthorization  Restart

G35 Multiple Sclerosis  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_  
 Description \_\_\_\_\_  
 Number of Relapses in Past Year \_\_\_\_\_  
 Date of Diagnosis \_\_\_\_\_  
 Date of last MRI \_\_\_\_\_ MRI Changes  Yes  No  
 Hepatitis B Screening  Positive  Negative (**Required for Ocrevus**)  
 Date of Screen: \_\_\_\_\_

Prior Treatment:  Avonex  Copaxone  Gilenya  Rebif  
 Extavia  Tecfidera  Other \_\_\_\_\_  
 Treatment Response \_\_\_\_\_  
 Treatment Dates \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 Lab Data \_\_\_\_\_  
 Concomitant Medications \_\_\_\_\_  
 Additional Comments \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Aubagio	<input type="checkbox"/> 7mg Tablet <input type="checkbox"/> 14mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 28 days <input type="checkbox"/> 30 days	
<input type="checkbox"/> Betaseron	<input type="checkbox"/> 0.3mg Vial & Diluent	<input type="checkbox"/> Inject 0.0625mg (0.25ml) SQ every other day and increase over a six-week period to 0.25mg (1ml) SQ every other day (Starter Dose) <input type="checkbox"/> Inject 0.25mg (1ml) SQ every other day	<input type="checkbox"/> 28 days	
<input type="checkbox"/> Copaxone	<input type="checkbox"/> 20mg Syringe <input type="checkbox"/> 40mg Syringe	<input type="checkbox"/> Inject 20mg SQ once daily <input type="checkbox"/> Inject 40mg SQ three times per week and at least 48 hours apart	<input type="checkbox"/> 28 days	
<input type="checkbox"/> Glatopa	<input type="checkbox"/> 20mg Syringe <input type="checkbox"/> 40mg Syringe	<input type="checkbox"/> Inject 20mg SQ once daily <input type="checkbox"/> Inject 40mg SQ three times per week and at least 48 hours apart	<input type="checkbox"/> 28 days	
<input type="checkbox"/> Kesimpta	<input type="checkbox"/> 20 mg/0.4 mL solution in a single-dose prefilled Sensoready® Pen <input type="checkbox"/> 20 mg/0.4 mL solution in a single-dose PFS	<input type="checkbox"/> Initial Dosing: 20 mg administered at Week 0, 1, and 2. <input type="checkbox"/> Subsequent Dosing: 20 mg administered monthly starting at Week 4	<input type="checkbox"/> 28 days	
<input type="checkbox"/> Ocrevus	<input type="checkbox"/> 300mg/10 mL single dose vial	<input type="checkbox"/> 300 mg intravenous infusion followed two weeks later by a second 300mg intravenous infusion (starter dose) <input type="checkbox"/> 600 mg intravenous infusion every 6 months	<input type="checkbox"/> 2 vials	
<input type="checkbox"/> Solu-Medrol	<input type="checkbox"/> 125mg Act-O-Vial System	<input type="checkbox"/> 125 mg administered intravenously 30 minutes prior to each Ocrevus infusion	<input type="checkbox"/> 1 vial <input type="checkbox"/> 2 vials	
<input type="checkbox"/> diphenhydramine	<input type="checkbox"/> 50mg/ml vial	<input type="checkbox"/> 50mg administered intravenously 30-60 minutes prior to each Ocrevus infusion	<input type="checkbox"/> 1 vial <input type="checkbox"/> 2 vials	
<input type="checkbox"/> Tecfidera	<input type="checkbox"/> 120mg Capsule <input type="checkbox"/> 240mg Capsule <input type="checkbox"/> Starter Pack	<input type="checkbox"/> Starting dose: 120 mg twice a day, orally, for 7 days <input type="checkbox"/> Maintenance dose after 7 days: 240 mg twice a day, orally <input type="checkbox"/> Take starter pack as directed	<input type="checkbox"/> 7 days <input type="checkbox"/> 30 days	
<input type="checkbox"/> Tysabri	<input type="checkbox"/> 300mg/15 mL vial	<input type="checkbox"/> 300 mg intravenous infusion over 1 hour every 4 weeks	<input type="checkbox"/> 1 vial	
<input type="checkbox"/> Solu-Medrol	<input type="checkbox"/> 125mg Act-O-Vial System	<input type="checkbox"/> 125 mg administered intravenously 30 minutes prior to each Tysabri infusion	<input type="checkbox"/> 1 vial	
<input type="checkbox"/> diphenhydramine	<input type="checkbox"/> 50mg/ml vial	<input type="checkbox"/> 50mg administered intravenously 30-60 minutes prior to each Tysabri infusion	<input type="checkbox"/> 1 vial	

Ship to:  Patient  Office  Other \_\_\_\_\_ Date: \_\_\_\_\_ Need by Date \_\_\_\_\_

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted  Dispense as Written

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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