



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
 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: _____

Additional information | Therapy New Reauthorization Restart
 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"/> Mayzent	<input type="checkbox"/> 0.25mg Tablet <input type="checkbox"/> 2mg Tablet	<input type="checkbox"/> Titration Dosing as directed <input type="checkbox"/> Take 1mg by mouth once daily <input type="checkbox"/> Take 2mg by mouth once daily		
<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	
<input type="checkbox"/> Uplizna	<input type="checkbox"/> 3 x 100mg/10mL SDV	<input type="checkbox"/> Initial dose: 300 mg intravenous infusion followed 2 weeks later by a second 300 mg intravenous infusion. Subsequent doses (starting 6 months from the first infusion): single 300 mg intravenous infusion every 6 months.		
<input type="checkbox"/> Zeposia	<input type="checkbox"/> 7 day Starter Pack <input type="checkbox"/> Starter Kit (1 month supply) <input type="checkbox"/> 0.92 mg maintenance	<input type="checkbox"/> Days 1-4 Take 0.23 mg once daily Days 5-7 Take 0.46 mg once daily Day 8 and thereafter Take 0.92mg once daily <input type="checkbox"/> Take 1 capsule by mouth once daily	<input type="checkbox"/> 1 Starter Pack <input type="checkbox"/> 30 days	

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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