Multiple Sclerosis
Enrollment Form

Phone: 844-309-7171
Fax: 844-309-7173

1. PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	
Date of Birth	SSN#	Weight_____kg/lbs	Height _______cm/in
Address	City	State	Zip
Phone # (Home)	(Work)	Email address	
Caregiver	Case manager		

2. INSURANCE INFORMATION

Primary Insurance RX Insurance: BIN_______ PCN______		Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

3. DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses)

☐ 340 Multiple Sclerosis	☐ Other ICD 9	Date of first demyelinating event	EDSS Score
Type: ☐ relapsing-remitting ☐ primary progressive ☐ secondary progressive ☐ progressing-relapsing			Is patient ambulatory? ☐ yes ☐ no
Is patient new to therapy? ☐ yes ☐ no If no, date therapy began		Date of diagnosis	

4. PREVIOUS MEDICATIONS (Please specify dosage & time on therapy)

Medication Strength & Dose	Dates of Therapy	Reason for Discontinuing

5. PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
☐ Avonex®	☐ AVOSTARTGRIP Titration Kit ☐ 30mcg Prefilled Syringe #4 ☐ 30mcg pen #4	☐ **Dose Titration:** - Week 1: Inject 7.5mcg IM once weekly - Week 2: Inject 15mcg IM once weekly - Week 3: Inject 22.5mcg IM once weekly - Week 4+: Inject 30mcg IM once weekly ☐ Inject 30mcg IM once weekly	4 wk supply	
☐ Betaseron®	☐ 0.3mg vial	☐ **Dose Titration:** - Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD - Weeks 3-4: Inject 0.125mg/0.50ml SQ QOD - Weeks 5-6: Inject 0.125mg/0.50ml SQ QOD - Weeks 7+: Inject 0.25mg/1ml SQ QOD ☐ **Maintenance Dose:** 0.25 mg/1ml SQ QOD ☐ **Other:** ______________________________	4 wk supply	
☐ Copaxone®	☐ 20mg Prefilled Syringe ☐ 40mg Prefilled Syringe	☐ 20mg SQ QD ☐ 20mg SQ 3x/wk, at least 48 hrs apart same 3 days each week	4 wk supply	
☐ Extavia®	☐ 0.3mg vial	☐ **Dose Titration:** - Weeks 1-2: Inject 0.0625mg/0.25ml SQ QOD - Weeks 3-4: Inject 0.125mg/0.50ml SQ QOD - Weeks 5-6: Inject 0.125mg/0.50ml SQ QOD - Weeks 7+: Inject 0.25mg/1ml SQ QOD ☐ **Maintenance Dose:** 0.25 mg/1ml SQ QOD ☐ **Other:** ______________________________	4 wk supply	
☐ Glatopa®	☐ 20mg Prefilled Syringe	☐ 20mg SQ QD	4 wk supply	
☐ Gilenya®	☐ 0.5mg capsule	☐ Take 0.5mg po QD	4 wk supply	
☐ Rebif® ☐ Rebif Rebidose®	☐ Titration Pack (8.8mcg/22mcg) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe	☐ Inject 8.8mcg subcutaneously 3x/wk weeks 1-2, 22mcg subcutaneously 3x/wk weeks 3-4, and 44mcg subcutaneously 3x/wk weeks 5+ (48 hrs apart) ☐ **Maintenance:** Inject 22mcg (0.5ml) SQ 3x/wk (48 hrs apart) ☐ **Maintenance:** Inject 44mcg (0.5ml) SQ 3x/wk (48 hrs apart) ☐ **Other:** ______________________________	4 wk supply	

6. DELIVERY INSTRUCTIONS

☐ Physicians Office ☐ Patient's Home	☐ Other	Date Medication Needed
	Address	
	City/State/Zip	

7. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty

Address	City/State/Zip
License #	DEA #

Physician's Signature ______________________________ **Date** ____________
(required to process prescription – stamped signatures are not permissible)

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.