Lumicera Health Services
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Multiple Sclerosis Enrollment Form

Ship to: ○ Patient ○ Office ○ Other Date: Needs by Date:

PATIENT INFORMATION

Patient Name ______
Address ______
Address 2 ______
City, State, ZIP ______
Preferred Phone ______ Type ______
Alternate Phone ______ Type ______
Email ______
DOB (mm/dd/yyyy) ______ Gender ○ Male ○ Female

PRESCRIBER INFORMATION

Prescriber Name ______ Specialty ______
State License # ______ UPIN ______
DEA ______ NPI ______
Group/Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Office Contact ______ Phone ______

INSURANCE INFORMATION *(Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical)*

CLINICAL INFORMATION

Diagnosis *(Please include diagnosis name and ICD-10)*

○ Diagnosis: ____________ICD-10 Code: _____________
Date of Diagnosis: _____________Date of last MRI:____________________
MRI changes: ○ Yes ○ No
Concomitant medications: ______________________________________
____
Weight: _________________ lbs/kgs Height :____________________in/cm
Is the patient pregnant, nursing, or planning pregnancy?: ○ Yes ○ No ○ N/A
Allergies: ____________________ Additional comments: _______________

Therapy: ○ New ○ Reauthorization ○ Restart
Serum Creatine: ______________ Creatine Clearance: ________________
Lab Data: Include copy of last CBC with differential: ____________________
Has the patient been previously treated for this condition? ○ Yes ○ No
Prior failed medication (medication and duration of treatment/reason for d/c):
_____________Number of relapses in past year:_________________
Who will administer injection? (if applicable): ______________________
Patient trained on injection? (if applicable): ○ Yes ○ No
Pharmacy injection training needed? (if applicable): ○ Yes ○ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
○Aubagio® (teriflunomide)	○ 7mg tablet ○ 14mg tablet	○ 7mg by mouth daily ○ 14mg by mouth daily ○ Other:		
○ Ampyra®(dalampridine)	○ 10mg tablet	○ 10mg by mouth twice daily ○ Other:		
○ Avonex® (interferon beta-1a)	○ 30mcg vials #4 ○ 30mcg prefilled syringe #4 ○ 30mcg Pen #4	○ Inject 30mcg intramuscular once weekly ○ Other: ○ **Dose Titration (available for SDV or for PFS using AVOSTARTGRIP™ Titration Kit)** • Week 1: inject 7.5mcg(0.25ml) intramuscular once weekly • Week 2: inject 15mcg(0.5ml) intramuscular once weekly • Week 3: inject 22.5mcg(0.75ml) intramuscular once weekly • Weeks 4+: inject 30mcg(1ml) intramuscular once weekly		
○ Betaseron® (interferon beta-1b) ○ Extavia®	○ 0.3mg vial	○ **Dose Titration** ○ Other: • Weeks 1-2: inject 0.0625mg/0.25ml subcutaneously every other day • Weeks 3-4: inject 0.125mg/0.50ml subcutaneously every other day • Weeks 5-6: inject 0.1875mg/0.75ml subcutaneously every other day • Weeks 7+: inject 0.25mg/1ml subcutaneously every other day ○ **Maintenance Dose:** 0.25mg/1ml subcutaneously every other day		
○ Copaxone® (glatiramer)	○ 20mg prefilled syringe ○ 40mg prefilled syringe	○ 20mg intramuscularly once daily ○ Other: ○ 40mg three times per week		
○ Gilenya®(fingolimod)	○ 0.5mg capsule	○ Take 0.5mg by mouth daily ○ Other:		
○ Plegridy® (peginterferon beta-1a)	○ Titration Pack (63mcg/94mcg) ○ Syringes ○ Pens ○ 125mcg ○ Prefilled pen ○ Prefilled syringe	○ Inject 63mcg subcutaneously on day 1, 94mcg on day 15, then 125 every 14 days thereafter ○ Inject 125mcg subcutaneously every 14 days		
○ Rebif® (interferon beta-1a)	○ Titration Pack (8.8mcg/22mcg) ○ Syringes ○ Rebidose ○ 22mcg Syringes ○ 22mcg Rebidose ○ 44mcg Syringes ○ 44mcg Rebidose	○ Inject 8.8mcg subcutaneously three times per week weeks 1-2, 22mcg subcutaneously three times per week weeks 3-4, and 44mcg subcutaneously three times per week weeks 5+ (48 hours apart) ○ **Maintenance:** Inject 22mcg (0.5ml) subcutaneously three times per week(48 hours apart) ○ **Maintenance:** Inject 44mcg (0.5ml) subcutaneously three times per week(48 hours apart) ○ Other:		
○ Tecfidera® (dimethyl fumerate)	○ Titration Pack ○ 120mg capsule ○ 240mg capsule	○ **Dose Titration:** ○ Other: • Week 1: 120mg by mouth twice a day for 7 days • Week 1+: 240mg by mouth twice a day ○ **Maintenance Dose:** 240mg by mouth twice a day		

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: ______________________________ ______________ ______________________
PRODUCT SUBSTITUTION PERMITTED *Date* *DISPENSE AS WRITTEN*