

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: _____

Therapy: New Continuing Therapy 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

Weight: _____ lbs/kgs Height: _____ in/cm
 Is the patient pregnant, nursing, or planning pregnancy?: Yes No N/A
 Allergies: _____ Additional comments: _____

PRESCRIPTION INFORMATION

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

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