



Phone: 844-265-1760  
 Fax: 877-342-2596

If patient is new to this medication, we strongly recommend filling out a manufacturer's hub enrollment form in order to receive patient support services offered by the hub when eligible. You may fax the manufacturer's hub enrollment form to our pharmacy.

# Multiple Sclerosis Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
 Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
 DEA \_\_\_\_\_  
 NPI \_\_\_\_\_  
 Group/Hospital \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

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

Additional Information

Therapy:  New  Reauthorization  Restart

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

## PRESCRIPTION INFORMATION

| Medication                                       | Dose / Strength  | Directions                               | Quantity | Refills |
|--|--|--|----------|---------|
| <input type="checkbox"/> Ampyra® (Dalfampridine) | <input type="checkbox"/> 10 mg Tablet  |  |          |         |
| <input type="checkbox"/> Aubagio®                | <input type="checkbox"/> 7 mg Tablet <input type="checkbox"/> 14 mg Tablet   |  |          |         |
| <input type="checkbox"/> Avonex®                 | <input type="checkbox"/> 30 mcg Syringe <input type="checkbox"/> 30 mcg Pen  |  |          |         |
| <input type="checkbox"/> Betaseron®              | <input type="checkbox"/> 0.3 mg Vial & Diluent   |  |          |         |
| <input type="checkbox"/> Copaxone® (Glatiramer)  | <input type="checkbox"/> 20 mg Syringe <input type="checkbox"/> 40 mg Syringe<br><input type="checkbox"/> Whisperject (1 time prescription for Glatiramer Products)  |  |          |         |
| <input type="checkbox"/> Extavia®                | <input type="checkbox"/> 0.3 mg Vial & Diluent   |  |          |         |
| <input type="checkbox"/> Gilenya®                | <input type="checkbox"/> 0.5 mg Capsule<br><input type="checkbox"/> First Dose Observation Complete? _____   |  |          |         |
| <input type="checkbox"/> Glatopa®                | <input type="checkbox"/> 20 mg Syringe <input type="checkbox"/> 40 mg Syringe  |  |          |         |
| <input type="checkbox"/> Ocrevus®                | <input type="checkbox"/> 300 mg/10 mL single dose vial<br><input type="checkbox"/> Nursing services by BriovaRx Infusion Services requested  |  |          |         |
| <input type="checkbox"/> Plegridy®               | <input type="checkbox"/> Prefilled Syringe Starter Pack <input type="checkbox"/> Pen Starter Pack<br><input type="checkbox"/> 125 mcg/0.5 mL Prefilled Syringe <input type="checkbox"/> 125 mcg/0.5 mL Pen   |  |          |         |
| <input type="checkbox"/> Rebif®                  | <input type="checkbox"/> Titration Pack <input type="checkbox"/> Rebidose® Auto-Injector Titration<br><input type="checkbox"/> 22 mcg Syringe <input type="checkbox"/> Rebidose® Auto-Injector 22 mcg<br><input type="checkbox"/> 44 mcg Syringe <input type="checkbox"/> Rebidose® Auto-Injector 44 mcg |  |          |         |
| <input type="checkbox"/> Tecfidera®              | <input type="checkbox"/> 120 mg Capsule <input type="checkbox"/> 240 mg Capsule<br><input type="checkbox"/> 30-Day Starter Pack  |  |          |         |
| <input type="checkbox"/> Vumerity™               | <input type="checkbox"/> 231 mg Capsule <input type="checkbox"/> 30-Day Starter Pack (231mg capsules)  |  |          |         |
| Lemtrada® Tysabri® Mavenclad™ Mayzent™           |  | Complete manufacturer enrollment program |          |         |

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs 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 authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this 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 \_\_\_\_\_ Supervising Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

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