Multiple Sclerosis Enrollment Form

Whole Health Pharmacy

Fax: 949-340-8008 Phone: 949-305-0788

□ **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
□ Aubagio	□ 7mg Tablet □ 14mg Tablet	□ Take 1 tablet by mouth once daily	□ 28 days □ 30 days	
□ Betaseron	□ 0.3mg Vial & Diluent	□ 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) □ Inject 0.25mg (1ml) SQ every other day	□ 28 days	
□ Copaxone	□ 20mg Syringe □ 40mg Syringe	□ Inject 20mg SQ once daily □ Inject 40mg SQ three times per week and at least 48 hours apart	□ 28 days	
□ Glatopa	□ 20mg Syringe □ 40mg Syringe	□ Inject 20mg SQ once daily □ Inject 40mg SQ three times per week and at least 48 hours apart	□ 28 days	
□ Kesimpta	□ 20 mg/0.4 mL solution in a single-dose prefilled Sensoready ® Pen □ 20 mg/0.4 mL solution in a single-dose PFS	□ Initial Dosing: 20 mg administered at Week 0, 1, and 2. □ Subsequent Dosing: 20 mg administered monthly starting at Week 4	□ 28 days	
□ Ocrevus □ Solu-Medrol □ diphenhydramine	□ 300mg/10 mL single dose vial □ 125mg Act-O-Vial System □ 50mg/ml vial	□ 300 mg intravenous infusion followed two weeks later by a second 300mg intravenous infusion (starter dose) □ 600 mg intravenous infusion every 6 months □ 125 mg administered intravenously 30 minutes prior to each Ocrevus infusion □ 50mg administered intravenously 30-60 minutes prior to each Ocrevus infusion	□ 2 vials □ 1 vial □ 2 vials □ 1 vial □ 2 vials	
□ Tecfidera	□ 120mg Capsule □ 240mg Capsule □ Starter Pack	□ Starting dose: 120 mg twice a day, orally, for 7 days □ Maintenance dose after 7 days: 240 mg twice a day, orally □ Take sturter pack as directed	□ 7 days □ 30 days	
□ Tysabri □ Solu-Medrol □ diphenhydramine	□ 300mg/15 mL vial □ 125mg Act-O-Vial System □ 50mg/ml vial	□ 300 mg intravenous infusion over 1 hour every 4 weeks □ 125 mg administered intravenously 30 minutes prior to each Tysarbi infusion □ 50mg administered intravenously 30-60 minutes prior to each Tysarbi infusion	□ 1 vial □ 1 vial □ 1 vial	

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: _____