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 demographi c 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	
□ Mayzent	□ 0.25mg Tablet □ 2mg Tablet	□ Titration Dosing as directed □ Take 1mg by mouth once daily □ Take 2mg by mouth once daily		
□ Ocrevus	□ 300mg/10 mL single dose vial	□ 300 mg intravenous infusion followed two weeks later by a second 300mg intravenous infusion (starter dose) □ 600 mg intravenous infusion every 6 months	□ 2 vials	
□ Solu-Medrol	□ 125mg Act-O-Vial System	□ 125 mg administered intravenously 30 minutes prior to each Ocrevus infusion	□ 1 vial □ 2 vials	
□ diphenhydramine	□ 50mg/ml vial	□ 50mg administered intravenously 30-60 minutes prior to each Ocrevus infusion	□ 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	□ 300mg/15 mL vial	□ 300 mg intravenous infusion over 1 hour every 4 weeks	□ 1 vial	
□ Solu-Medrol	□ 125mg Act-O-Vial System	□ 125 mg administered intravenously 30 minutes prior to each Tysarbi infusion	□ 1 vial	
□ diphenhydramine	□ 50mg/ml vial	□ 50mg administered intravenously 30-60 minutes prior to each Tysarbi infusion	□ 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: _____