

WHOLE HEALTH PHARMACY

Multiple Sclerosis Enrollment Form

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

□ Urgent Request

Rep:

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Please complete the following or send patient demographic sheet					
Patient Name			Prescriber Name		
Address			DEA		
Address 2			NPI		
City, State, Zip			Address		
City, State, Zip Mobile Phone Mobile Phone			Address		
DOBLast Four of SS Gender			City, State, Zip Fax		
Language Preference			Control Dover		
	lance fav. av amail valavant elinian		Contact Person	nui au au thaui-at	ian.
Clinical Diagnosis: please fax or email relevant clinical notes, la Diagnosis - Please include diagnosis name with ICD-10 code			Additional information Therapy New Reauthorizat		lon
Diagnosis - Flease include diagnosis flame with 1cb-10 code			Additional information Therapy New Reauthorizat	JUII REStait	
□ G35 Multiple Sclerosis □ Other Diagnosis: ICD-10 Code			Prior Treatment: Avonex Copaxone Gilenya Rebif Extavia Tecfidera Other		
Description			Treatment Response		
Number of Relapses in Past Year			Treatment Dates		
Date of Diagnosis MRI Changes Yes No			Allergies		
			Lab Data Concomitant Medications		
Hepatitis B Screening Positive Negative (Required for Ocrevus) Date of Screen:			Additional Comments		
PRESCRIPTION INFORMATION					
NA 11 11		SCRIPI		0 1"	D CIII
Medication	Dose/Strength		Directions	Quantity	Refills
□ Aubagio	□ 7mg Tablet □ 14mg Tablet	□ Take 1	1 tablet by mouth once daily	□ 28 days □ 30 days	
			0.0505 (0.05 1) 00 11 1 11	20.1	
- Detroover - 0.2mm Viol 9. Dilyont		□ Inject 0.0625mg (0.25ml) SQ every other day and increase		□ 28 days	
□ Betaseron			six-week period to 0.25mg (1ml) SQ every other day		
			er Dose)		
			0.25mg (1ml) SQ every other day	20.1	
□ Copaxone	□ 20mg Syringe	□ Inject	20mg SQ once daily	□ 28 days	
	□ 40mg Syringe	_	40mg SQ three times per week and at least 48 hours		
□ Glatopa	□ 20mg Syringe	apart □ Inject 20mg SQ once daily □ 28 days		= 29 days	
🛮 🖰 Спасора	□ 2011g Syringe □ 40mg Syringe	□ Inject 20mg SQ once daily □ Inject 40mg SQ three times per week and at least 48 hours		□ 20 uays	
	1 Horng Syringe	apart	Torng SQ trifee times per week and at least to flours		
□ Ocrevus	□ 300mg/10 mL single dose vial		g intravenous infusion followed two weeks later by a	□ 2 vials	
- Ocievas	500mg/10 me single dose viai		d 300mg intravenous infusion (starter dose)	□ Z Vidi3	
			□ 600 mg intravenous infusion every 6 months		
□ Solu-Medrol			ig administered intravenously 30 minutes prior to each	□ 1 vial	
= 125mg /icc o viai system		Ocrevus infusion		□ 2 vials	
□ diphenhvdramine	□ diphenhydramine □ 50mg/ml vial □ 50r		administered intravenously 30-60 minutes prior to	□ 1 vial	
,,,,,			Ocrevus infusion	□ 2 vials	
□ Tecfidera			ng dose: 120 mg twice a day, orally, for 7 days	□ 7 days	
Techidera	□ 240mg Capsule				
	□ Starter Pack		sturter pack as directed	□ 30 days	
	- Starter rack	□ rake s	starter pack as affected		
□ 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		□ 1 vial	
a solu i ledi oi	125mg / Cc O viai System		pi infusion	- I Viai	
□ diphenhydramine	□ 50mg/ml vial		administered intravenously 30-60 minutes prior to		
,			Tysarbi infusion	□ 1 vial	
			.,,		
Ship to: Patient Office Other Date: Need				Date	1
**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:					
CONFIDENTIALITY STATEMENT: This communication is intended for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination distribution, or copying of the communication is strictly prohibited. If you have received this communication is entering the properties of the communication is entering the properties.					