**Whole Health Pharmacy**

# Multiple Sclerosis Enrollment Form

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<br>□ 14mg Tablet | □ Take 1 tablet by mouth once daily | □ 28 days<br>□ 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)<br>□ Inject 0.25mg (1ml) SQ every other day | □ 28 days | |
| □ Copaxone | □ 20mg Syringe<br>□ 40mg Syringe | □ Inject 20mg SQ once daily<br>□ Inject 40mg SQ three times per week and at least 48 hours apart | □ 28 days | |
| □ Glatopa | □ 20mg Syringe<br>□ 40mg Syringe | □ Inject 20mg SQ once daily<br>□ 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<br>□ 20 mg/0.4 mL solution in a single-dose PFS | □ Initial Dosing: 20 mg administered at Week 0, 1, and 2.<br>□ Subsequent Dosing: 20 mg administered monthly starting at Week 4 | □ 28 days | |
| □ Mayzent | □ 0.25mg Tablet<br>□ 2mg Tablet | □ Titration Dosing as directed<br>□ Take 1mg by mouth once daily<br>□ Take 2mg by mouth once daily | | |
| □ Ocrevus<br><br>□ Solu-Medrol<br><br>□ diphenhydramine | □ 300mg/10 mL single dose vial<br><br>□ 125mg Act-O-Vial System<br><br>□ 50mg/ml vial | □ 300 mg intravenous infusion followed two weeks later by a second 300mg intravenous infusion (starter dose)<br>□ 600 mg intravenous infusion every 6 months<br>□ 125 mg administered intravenously 30 minutes prior to each Ocrevus infusion<br>□ 50mg administered intravenously 30-60 minutes prior to each Ocrevus infusion | □ 2 vials<br><br>□ 1 vial<br>□ 2 vials<br>□ 1 vial<br>□ 2 vials | |
| □ Tecfidera | □ 120mg Capsule<br>□ 240mg Capsule<br>□ Starter Pack | □ Starting dose: 120 mg twice a day, orally, for 7 days<br>□ Maintenance dose after 7 days: 240 mg twice a day, orally<br>□ Take starter pack as directed | □ 7 days<br>□ 30 days | |
| □ Tysabri<br><br>□ Solu-Medrol<br><br>□ diphenhydramine | □ 300mg/15 mL vial<br><br>□ 125mg Act-O-Vial System<br><br>□ 50mg/ml vial | □ 300 mg intravenous infusion over 1 hour every 4 weeks<br><br>□ 125 mg administered intravenously 30 minutes prior to each Tysabri infusion<br>□ 50mg administered intravenously 30-60 minutes prior to each Tysabri infusion | □ 1 vial<br><br>□ 1 vial<br><br>□ 1 vial | |
| □ Uplizna | □ 3 x 100mg/10mL SDV | □ Initial dose: 300 mg intravenous infusion followed 2 weeks later by a second 300 mg intravenous infusion.<br>□ Subsequent doses (starting 6 months from the first infusion): single 300 mg intravenous infusion every 6 months. | | |
| □ Zeposia | □ 7 day Starter Pack<br>□ Starter Kit (1 month supply)<br>□ 0.92 mg maintenance | □ Days 1-4 Take 0.23 mg once daily<br>Days 5-7 Take 0.46 mg once daily<br>Day 8 and thereafter Take 0.92mg once daily<br>□ Take 1 capsule by mouth once daily | □ 1 Starter Pack<br>□ 30 days | |

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: ____________________

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