



Phone: 844-265-1760
Fax: 877-342-4596

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"/> 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"/> Dalfampridine	<input type="checkbox"/> 10 mg ER Tablet			
<input type="checkbox"/> Extavia®	<input type="checkbox"/> 0.3 mg Vial & Diluent			
<input type="checkbox"/> Gilenya®	<input type="checkbox"/> 0.5 mg Capsule <input type="checkbox"/> First Dose Observation Complete? _____			
<input type="checkbox"/> Glatiramer	<input type="checkbox"/> 20 mg Pre-Filled Syringe <input type="checkbox"/> 40 mg Pre-Filled Syringe			
<input type="checkbox"/> Ocrevus®	<input type="checkbox"/> 300 mg/10 mL single dose vial <input type="checkbox"/> Nursing services by BrivoRx Infusion Services requested			
<input type="checkbox"/> Plegridy®	<input type="checkbox"/> Prefilled Syringe Starter Pack <input type="checkbox"/> Pen Starter Pack <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 <input type="checkbox"/> 22 mcg Syringe <input type="checkbox"/> Rebidose® Auto-Injector 22 mcg <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 <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)			
<input type="checkbox"/> Zeposia	<input type="checkbox"/> 0.23 mg Capsule <input type="checkbox"/> 7-Day Starter Pack <input type="checkbox"/> 0.46 mg Capsule <input type="checkbox"/> 37-Day Starter Kit (Starter Pack + <input type="checkbox"/> 0.92 mg Capsule 0.92 mg 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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