Multiple Sclerosis Enrollment Form A-F

VALUE SPECIALTY PHARMACY

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
SSN #: XXX-XX-_____
Known Allergies: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Primary Language: _____
Alternate Caregiver Name: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Secondary Insurance: _____
Policy: _____ Group#: _____
Policy: _____ Group#: _____

Clinical Information

Diagnosis: ☐ G35 Multiple Sclerosis ☐ Other: _____ ICD 10 code: _____
Date of Diagnosis: _____/_____/_____

Type: ☐ Relapsing-Remitting ☐ Secondary progressive with relapses ☐ Primary progressive ☐ Secondary progressive without relapses
☐ Clinically-Isolated Syndrome (CIS) ☐ Progressive-relapsing

Number of Relapses in the Past Year: _____ Date of Last MRI: _____/_____/_____ MRI Changes ☐ Yes ☐ No

Has patient been previously treated for this condition? ☐ Yes ☐ No
If yes, medication/therapy failed (length of therapy): _____

Prescription

Medication	Strength	Directions	Quantity	Refills
☐ Avonex®	☐ 30mcg PFS ☐ 30mcg Pen	Inject 30mcg intramuscularly once weekly	#4	
☐ Betaseron®	☐ 0.3mg vial ☐ 0.3mg PFS	☐ Induction dose: Weeks 1-2: Inject 0.0625mg (0.25ml) subcutaneously every other day Weeks 3-4: Inject 0.125mg (0.5ml) subcutaneously every other day Weeks 5-6: Inject 0.1875mg (0.75ml) subcutaneously every other day	Quantity Sufficient 6 weeks	0 refills
		☐ Maintenance dose: Inject 0.25mg (1ml) subcutaneously every other day	#14	
☐ Copaxone® *For generic equivalent please see G-M form*	☐ 20mg PFS	Inject 1 syringe (20mg) subcutaneously once daily	#30	
	☐ 40mg PFS	Inject 1 syringe (40mg) subcutaneously 3 times weekly	#12	
☐ Extavia®	0.25mg vial	☐ Induction dose: Weeks 1-2: Inject 0.0625mg (0.25ml) subcutaneously every other day Weeks 3-4: Inject 0.125mg (0.5ml) subcutaneously every other day Weeks 5-6: Inject 0.1875mg (0.75ml) subcutaneously every other day	Quantity Sufficient 6 weeks	0 refills
		☐ Maintenance dose: Inject 0.25mg (1ml) subcutaneously every other day	#15	

Supportive

Medication	Strength	Directions	Quantity	Refills
☐ Ampyra® *generic equivalent*	10mg tablet	Take one tablet orally _____ daily.		

Is patient new to this therapy: ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
Practice Name: _____ Contact: _____
Address: _____ Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right. ☐