



Multiple Sclerosis Enrollment Form A-F

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
<input type="checkbox"/> Avonex®	<input type="checkbox"/> 30mcg PFS <input type="checkbox"/> 30mcg Pen	Inject 30mcg intramuscularly once weekly	#4	
<input type="checkbox"/> Betaseron®	<input type="checkbox"/> 0.3mg vial <input type="checkbox"/> 0.3mg PFS	<input type="checkbox"/> 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
		<input type="checkbox"/> Maintenance dose: Inject 0.25mg (1ml) subcutaneously every other day	#14	
<input type="checkbox"/> Copaxone® <i>For generic equivalent please see G-M form</i>	<input type="checkbox"/> 20mg PFS	Inject 1 syringe (20mg) subcutaneously once daily	#30	
	<input type="checkbox"/> 40mg PFS	Inject 1 syringe (40mg) subcutaneously 3 times weekly	#12	
<input type="checkbox"/> Extavia®	0.25mg vial	<input type="checkbox"/> 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
		<input type="checkbox"/> Maintenance dose: Inject 0.25mg (1ml) subcutaneously every other day	#15	

Supportive

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Ampyra® <i>generic equivalent</i>	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.

fax referral to: 844-812-6227 | phone: 855-265-8008 | www.vsprx.com