encore pharmacy

Multiple Sclerosis Enrollment Form

Fax to: 512-490-6515

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
Phone: 512-381-1708
Toll Free: 855-241-6658
11209 Metric Blvd., Suite B4
Austin, TX 78758

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ ☐ MALE ☐ FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

INSURANCE INFORMATION

Please Fax Copy Of Insurance Card (Front & Back) Also Fax Clinical Notes, Labs, and Test with Referral Form

CLINICAL INFORMATION

DIAGNOSIS Date of Diagnosis: _____ ☐ G35. Multiple Sclerosis ☐ Other: _____ Height: _____ Weight: _____kg

Type: ☐ Relapsing-remitting ☐ Primary progressive ☐ Secondary Progressive ☐ Progressive-Remitting Allergies _____ ☐ NKDA

Other medications patient is currently taking, including OTCs, with dose & directions (or fax medication profile: _____

Has patient been treated previously for this condition? ☐ Yes ☐ No Medication(s) failed: _____

Is patient currently on therapy? ☐ Yes ☐ No – Type/medication: _____

Will patient stop taking above medication(s) before starting the new medication? ☐ Yes ☐ No If yes, how long should patient wait before starting the new medication? _____

Date of last MRI: _____ Changes? ☐ Yes ☐ No Number of relapses in the past year: _____ Is patient pregnant or breastfeeding? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

☐ Zeposia

INITIAL DOSE:

☐ Starter Kit (0.23/0.46 capsule)

☐ Starter Kit: Days 1-4: Take 0.23mg by mouth once daily. Days 5-7: Take 0.46mg by mouth once daily.

QTY: ☐ 1 Kit (7 capsules) Refills: _____

MAINTENANCE DOSE:

☐ 0.92mg capsule

☐ Days 8 and thereafter: Take 1 capsule (0.92mg) by mouth once daily.

QTY: ☐ 30 capsules Refills: _____

☐ Ocrevus

☐ 300mg/10ml

INITIAL DOSE:

☐ *300mg via intravenous infusion followed by a second dose of 300mg via intravenous infusion two weeks later (Must be diluted according to manufacturer recommendations prior to administration)*

MAINTENANCE DOSE:

☐ *600mg via intravenous infusion every 6 months (Must be diluted according to manufacturer recommendations prior to administration)*

QTY: ☐ 1 vial ☐ 2 vials Refills: _____

☐ Kesimpta

☐ 20 mg/0.4 mL solution in a single-dose prefilled Sensoready® Pen

INITIAL DOSE:

☐ Inject 20mg SQ at Week 0, 1 & 2.

MAINTENANCE DOSE:

☐ Inject 20mg SQ administered monthly starting at Week 4.

☐ 1 Sensoready Pen
☐ 2 Sensoready Pens
☐ 3 Sensoready Pens
☐ Other _____

Refills: _____

GLATIRAMER

☐ Copaxone®

☐ 20mg/mL Prefilled Syringe
☐ 40mg/mL Prefilled Syringe
☐ Inject 20mg SC daily
☐ Inject 40mg SC three times per week
☐ Other _____

QTY: ☐ 1 kit/ 30 syringes
☐ 1 kit/ 12 syringes
☐ Other _____ Refills: _____

☐ Glatopa™

☐ 20mg/ml Prefilled Syringe
☐ 40mg/ml Prefilled Syringe
☐ Inject 20mg SC daily
☐ Inject 40mg SC 3 times per week
☐ Other _____

QTY: ☐ 1 kit/ 30 syringes
☐ 1 kit/ 12 syringes
☐ Other _____ Refills: _____

☐ Gilenya® (fingolimod)

☐ 0.5mg capsules
☐ Take 1 capsule by mouth daily
☐ Other _____

QTY: ☐ 30 capsules
☐ Other _____ Refills: _____

☐ Dalfampridine

☐ 10mg ER tablet
☐ Take 1 tablet (10mg) by mouth every 12 hours with or without food.

QTY: ☐ 60 tablets Refills: _____

☐ Other: _____

☐ Dose: _____

☐ Instruction: _____

QTY: _____ Refills: _____

INTERFERON BETA 1A

☐ Avonex®

☐ 30mcg/0.5ml Pen
☐ 30mcg/0.5ml Prefilled Syringe
☐ Inject 30mcg IM weekly ☐ Other _____

QTY: ☐ 4 ☐ Other _____ Refills: _____

☐ Rebif®

☐ Rebif® Prefilled Syringes
☐ Rebif Rebidose® Autoinjector Pens
☐ 22 mcg/0.5ml ☐ 44 mcg/0.5ml

INITIAL TITRATION DOSE:

☐ Titration Pack ____ (8.8mcg/22mcg Prefilled Syringes)
☐ Titration Pack ____ (8.8mcg/22mcg Autoinjector Pens)
☐ Inject 4.4 mcg SC three times per week on weeks 1-2, then 11 mcg SC three times per week on weeks 3-4, then maintenance dosing.
☐ Inject 8.8mcg SC three times per week on weeks 1-2, then 22mcg SC three times per week on weeks 3-4, then maintenance dosing.
☐ Other _____

QTY: ☐ 4 week supply (12 syringes)
☐ Other _____ Refills: _____

MAINTENANCE DOSE:

☐ 22mcg/0.5ml Prefilled Syringes
☐ 44mcg/0.5ml Prefilled Syringes
☐ 22mcg/0.5ml Autoinjector Pens
☐ 44mcg/0.5ml Autoinjector Pens
☐ Inject 22mcg SC three times per week(48 hrs apart).
☐ Inject 44mcg SC three times per week (48 hrs apart).
☐ Other _____

QTY: ☐ _____ Refills: _____

☐ Plegridy

☐ Subcutaneous Pen Starter Pack Rx (first month)*
☐ Maintenance Rx (months 2–13)

INITIAL DOSE: ☐ Inject 63mcg day 1 and 94mcg day 15. Inject 125mg day 29 and every 14 days thereafter

MAINTENANCE DOSE: ☐ Inject 125mcg every 14 days

QTY: ☐ Starter Kit #1 kit/2 syringes
☐ Maintenance Kit #1 kit/2 syringes
☐ Other _____ Refills: _____

INTERFERON BETA 1B

☐ Betaseron®

INITIAL TITRATION DOSE: ☐ 0.3mg vial
☐ Week 1-2: Inject 0.0625mg/0.25ml SC every other day
☐ Week 3-4: Inject 0.125mg/0.5ml SC every other day
☐ Week 5-6: Inject 0.1875mg/0.75ml SC every other day
☐ Week 7+: Inject 0.25mg/1ml SC every other day
☐ Other _____

QTY: ☐ 28 Day Supply (1 Kit / 14 Vials)
☐ Other _____ Refills: _____

MAINTENANCE DOSE:
☐ 0.3mg vial
☐ Inject 0.25mg/1ml SC every other day
☐ Other _____

QTY: ☐ 28 Day Supply (1 Kit / 14 Vials)
☐ Other _____ Refills: _____

☐ Extavia®

INITIAL TITRATION DOSE: ☐ 0.3mg vial
☐ Week 1-2: Inject 0.0625mg/0.25ml SC every other day
☐ Week 3-4: Inject 0.125mg/0.5ml SC every other day
☐ Week 5-6: Inject 0.1875mg/0.75ml SC every other day
☐ Week 7+: Inject 0.25mg/1ml SC every other day
☐ Other _____

QTY: ☐ 4 week supply
☐ Other _____ Refills: _____

MAINTENANCE DOSE: ☐ 0.3mg vial
☐ Inject 0.25mg/1ml SC every other day
☐ Other _____

QTY: ☐ 4 week supply
☐ Other _____ Refills: _____

☐ Dimethyl Fumarate (Tecfidera)

☐ 30-day starter pack ☐ 120 mg capsules
☐ 240 mg capsules

INITIAL DOSE:
☐ Take 120 mg PO BID x 7 days + 240 mg PO BID x 23 days

MAINTENANCE DOSE:
☐ Take 120 mg PO BID
☐ Take 240 mg PO BID
☐ Other _____

QTY: ☐ 56 capsules ☐ 60 capsules
☐ Other _____ Refills: _____

NOTES / OTHER

INJECTION TRAINING

☐ Patient has received injection training ☐ Physician Office to provide injection training ☐ Pharmacy to provide injection training

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____

Telephone: _____ Fax: _____ Email: _____

Office Address: _____ City: _____ State: _____ Zip: _____

NPI # : _____ DEA # : _____ TAX ID # : _____ Medicaid Provider # : _____

_____ _____ * _____

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.