

Multiple Sclerosis Enrollment Form

 **Express Health Mart Pharmacy**
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6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: Male Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

340 Multiple Sclerosis Relapsing/Remitting Progressive Other: _____
Height: _____ Weight: _____ Allergies: _____ Has patient received injection training? Yes No

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Aubagio®	<input type="checkbox"/> 7mg <input type="checkbox"/> 14mg	<input type="checkbox"/> Take one 7mg tablet by mouth once a day. <input type="checkbox"/> Take one 14mg tablet by mouth once a day.	<input type="checkbox"/> 28-day supply (1 box) <input type="checkbox"/> 84-day supply (3 boxes) <input type="checkbox"/> _____	
<input type="checkbox"/> Avonex®	<input type="checkbox"/> 30mcg Prefilled Syringe <input type="checkbox"/> 30mcg Single Dose Vial <input type="checkbox"/> 30 mcg Avonex Pen (single dose)	Inject 30mcg intramuscularly once a week.	<input type="checkbox"/> 4-week supply (1 kit) <input type="checkbox"/> 12-week supply (3 kits)	
<input type="checkbox"/> Betaseron®	0.3mg	<input type="checkbox"/> Inject 0.25mg (1ml) subcutaneously every other day <input type="checkbox"/> Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD <input type="checkbox"/> Other: _____	<input type="checkbox"/> 28-day supply (1 kit of 14 vials) <input type="checkbox"/> 84-day supply (3 kits of 14 vials) <input type="checkbox"/> _____	
<input type="checkbox"/> BETAJECT® Lite Autoinjector		Use as directed		
<input type="checkbox"/> Copaxone®	20mg Prefilled Syringe	Inject 20mg subcutaneously daily.	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits)	
<input type="checkbox"/> Autoject® 2 for glass syringe injection device		Use as directed	1	PRN
<input type="checkbox"/> Extavia®	0.3mg	<input type="checkbox"/> Inject 0.25mg (1ml) subcutaneously every other day <input type="checkbox"/> Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits)	
<input type="checkbox"/> EXTAVIA® Auto-Injector II		Use as directed.		
<input type="checkbox"/> Gilenya™	0.5 mg	Take one 0.5 mg capsule by mouth once daily	<input type="checkbox"/> 28-day supply (1 box) <input type="checkbox"/> 84-day supply (3 boxes) <input type="checkbox"/> _____	
<input type="checkbox"/> Novantrone®	<input type="checkbox"/> 10mg/5ml multidose vial <input type="checkbox"/> 20mg/10ml multidose vial	<input type="checkbox"/> Dilute and administer 12mg/m ² as intravenous infusion every 3 months. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Rebif®	<input type="checkbox"/> Titration Pack (six 8.8mcg & six 22mcg prefilled syringes) <input type="checkbox"/> 22mcg prefilled syringe <input type="checkbox"/> 44mcg prefilled syringe <input type="checkbox"/> Titration Pack Rebidoose® (six 8.8 mcg pre-filled autoinjectors and six 22 mcg pre-filled autoinjectors) <input type="checkbox"/> Rebidoose® 22 mcg pre-filled autoinjector <input type="checkbox"/> Rebidoose® 44mcg pre-filled autoinjector	<input type="checkbox"/> Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ <input type="checkbox"/> Inject 44mcg subcutaneously three times a week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4-week supply (1 kit) <input type="checkbox"/> 12-week supply (3 kits) <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Rebiject®		Use as directed.	1	PRN
<input type="checkbox"/> Tecfidera™	<input type="checkbox"/> Titration Starter Pack (14 capsules of 120 mg and 46 capsules of 240 mg) <input type="checkbox"/> 240 mg capsules <input type="checkbox"/> 120 mg capsules	<input type="checkbox"/> Titration Starter Pack: take 120 mg capsule by mouth twice a day for 7 days followed by 240 mg capsule by mouth twice a day <input type="checkbox"/> Maintenance dose: take 240 mg capsule by mouth twice a day <input type="checkbox"/> Other: _____	<input type="checkbox"/> Titration Starter Pack: 30 day supply <input type="checkbox"/> Maintenance Dose (240 mg): <input type="checkbox"/> 30 day supply <input type="checkbox"/> 90 day supply <input type="checkbox"/> Other: _____ <input type="checkbox"/> 120 mg capsules: <input type="checkbox"/> 7 day supply <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Tysabri®	Please complete a MS TOUCH/Tysabri enrollment form and indicate CVS Caremark as your preferred pharmacy provider. (Please contact TOUCH Prescribing Program with any questions: 1-800-456-2255)			
<input type="checkbox"/>				

Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6 **X** **PHYSICIAN SIGNATURE REQUIRED** **X**
DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. MS 062713