MULTIPLE SCLEROSIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: ______________________ Caregiver: ______________________

DOB: ________ Male Female Weight: _______ kgs or lbs (check one) Height: _______ in or cm (check one) Recorded Date: ________

Address: ______________________ City: ______________________ State: ________ Zip: ________

Best Phone #:______________________ Cell Alternate Phone #:______________________ Cell Email:______________________

Allergies: ______________________ Latex Allergy: Yes No

ICD-10 Code for requested therapy: ______________________ ICD-10 Code(s) for other medical conditions: ______________________

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

G35 Date of first demyelinating event: ______________________

Type: Clinically isolated syndrome Relapsing-remitting Secondary-progressive Primary-progressive Progressive-relapsing

Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):

Prior therapies: ______________________ Reason for discontinuation: ______________________

Therapy: New Reauthorization Other ______________________

Has pregnancy been excluded? (check one): No Yes

First dose observation date (anticipated/complete): ______________________ TB test date: ______________________ Result: ______________________

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Aubagio® (teriflunomide) Enroll in MS One to One®	14mg tablet 7mg tablet	Take 1 tablet by mouth daily	30-day supply	________
Avonex® (interferon beta-1a) Enroll in Above MS™	30mcg Prefilled Syringe 25G 1″ Needles 30mcg Avonex Pen (single dose)	Inject 30mcg intramuscularly every week	4-week supply (1 kit)	________
Betaseron® (interferon beta-1b) Enroll in BETAPLUS®	0.3mg	Inject 0.25mg (1ml) Sub-Q every other day Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml Sub-Q QOD • Weeks 3-4: Inject 0.125mg/0.50ml Sub-Q QOD • Weeks 5-6: Inject 0.1875mg/0.75 Sub-Q QOD • Weeks 7+: Inject 0.25mg/1ml Sub-Q QOD Other: ________	28-day supply (1 kit of 14 vials) Other: ________	________
Copaxone® (glatiramer) Enroll in Shared Solutions® Enroll in Mylan MS ADVOCATE®	20mg Prefilled Syringe 40mg Prefilled Syringe	Inject 20mg Sub-Q daily Inject 40mg Sub-Q 3 times weekly	30-day supply (1 kit)	________
Extavia® (interferon beta-1b) Enroll in EXTAVIA® Go	0.3mg	Inject 0.25mg (1ml) Sub-Q every other day Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml Sub-Q QOD • Weeks 3-4: Inject 0.125mg/0.50ml Sub-Q QOD • Weeks 5-6: Inject 0.1875mg/0.75 Sub-Q QOD • Weeks 7+: Inject 0.25mg/1ml Sub-Q QOD Other: ________	30-day supply (1 kit)	________
Gilenya™ (fingolimod) Enroll in Gilenya® Go	0.25 mg 0.5 mg	Take one 0.25 mg capsule every day Take one 0.5 mg capsule every day	28-day supply 30-day supply Other: ________	________
Glatopa™ (glatiramer) Enroll in GlatopaCare®	20mg Prefilled Syringe 40mg Prefilled Syringe	Inject 20mg Sub-Q daily Inject 40mg Sub-Q 3 times weekly	30-day supply (1 kit)	________
Rebif® (interferon beta-1a) Enroll in MSLifelines®	Titration Pack (six 8.8mcg & six 22mcg prefilled syringes) 22mcg Prefilled Syringe 44mcg Prefilled Syringe Titration Pack Rebidose (six 8.8 mcg pre-filled autoinjectors and six 22 mcg pre-filled autoinjectors) Rebidose® 22mcg Prefilled Autoinjector Rebidose® 44mcg Prefilled Autoinjector	Inject 8.8mcg Sub-Q three times a week weeks 1-2, 22mcg Sub-Q three times a week weeks 3-4, and 44mcg Sub-Q three times a week weeks 5+ Inject 44mcg Sub-Q three times a week Other: ________	4-week supply (1 kit) Other: ________	________
Other				________

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Patient: ______________________________________ DOB: _____________

LIMITED DISTRIBUTION DRUGS

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Ampyra® (dalfampridine ER) Enroll in AMPYRA Patient Support Services	10mg ER tablet	Take 1 tablet (10mg) every 12 hours	30-day supply	__________
Lemtrada® (alemtuzumab) Enroll in MS One to One®	12mg/1.2mL Single Dose Vial	Infuse 12mg IV daily for 5 consecutive days Infuse 12mg IV daily for 3 consecutive days		__________
Mavenclad® (cladribine) Enroll in MSLifelines®	10mg tablet	Please attach separate prescription		__________
Mayzent® (siponimod) Enroll in Alongside MS™	0.25mg tablet 2mg tablet	Please attach separate prescription		__________
Ocrevus™ (ocrelizumab) Enroll in OCREVUS CONNECTS®	300mg/10mL Single Dose Vial	Infuse 300mg IV as a single dose, followed by 300mg IV infusion 2 weeks later Infuse 600mg IV every 6 months	2 vials	__________
Plegridy™ (peginterferon beta-1a) Enroll in Above MS™	125mcg Prefilled Syringe 125 mcg Plegridy Pen Plegridy Pen starter pack (One 63mcg and one 94mcg) Starter Pack prefilled syringes (One 63mcg and one 94mcg)	Inject 125mcg Sub-Q every two weeks Dose titration: Inject • 63mcg SUB-Q on day 1 • 94mcg SUB-Q on day 15 • 125mcg SUB-Q on day 29	28-day supply (1 kit)	__________
Tecfidera® (dimethyl fumarate) Enroll in Above MS™	30-Day Starter Pack (14 capsules of 120mg & 46 capsules of 240mg) 120mg DR capsule 240mg DR capsule	Take 120mg by mouth 2 times daily for 7 days then 240mg by mouth 2 times daily Take 240mg by mouth 2 times daily Other:________________________________	30-day Starter Pack 30-day supply	__________
Tysabri® (natalizumab) Enroll in Above MS™	300mg/15mL Single Dose Vial	Infuse 300mg IV every 4 weeks	28-day supply	__________
Other				__________

INJECTION TRAINING: **OFFICE TO COORDINATE** **HEALTHDYNE SPECIALTY TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: ________________________________ Prescriber Specialty: ____

Ship to: Patient Physician Clinic Other: ____

Fax #: ________________________________ Contact Name: ____

Office Address: ____________________________________ City: __________________________ State: __________ Zip: ____________

The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: ________________________________ Prescriber's Signature: ________________________________ Date: ______________

Use substitution Dispense as written

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