NEUROLOGY ENROLLMENT FORM: SPECIALTY

PATIENT INFORMATION

Last Name ____________ First Name ____________

Social Security No ____________ Date of Birth ____________

Sex □ M □ F Weight_______ Height_______ Allergies________________

Home Phone ____________ Work/Mobile ____________

Home Address ____________

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ____________ Medical Insurance Phone ____________

Rx Card (PBM) ____________ Group No ____________

Prescription Card Bin # ____________ PCN # ____________

TREATMENT ARRANGEMENTS

•Start Date:_________________ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Doctor's Office □ Other:________________________

STATEMENT OF MEDICAL NECESSITY: Diagnosis: □ G35 Multiple Sclerosis -> □ Relapsing/Remitting □ Progressive □_________ Date of Diagnosis:___________

•Is Patient using prescribed therapy in combination with other biologics for MS? □ Yes □ No

•Is Patient pregnant, nursing, or planning pregnancy? □ Yes □ No □ N/A Allergies:____

Tried and failed Medications: ____

HEP-B Test Result: □ Positive □ Negative Date: ______________________

MULTIPLE SCLEROSIS

MEDICATION	DOSE FORM & STRENGTH	DIRECTIONS	QUANTITY	REFILL
□ **Avonex®**	□ 30mcg Prefilled Syringe □ 30mcg Single Dose Vial □ 30mcg Avonex Pen	□ Inject 30mcg IM once a week. □ Dose Titration: Week 1 Admin 7.5mcg IM; Week 2 Admin 15mcg IM; Week 3 Admin 22.5mcg IM; Week 4+ Admin 30mcg IM.	□ 1 kit □ 3 kits	....
□ **Betaseron® or** □ **Extavia®**	□ 0.3mg Vial	□ Inject 0.25mg(1ml) Sub-Q every other day. □ Dose Titration: Weeks 1-2: Inject 0.0625mg/0.25ml QOD Sub-Q; Weeks 3-4: Inject 0.125mg/0.50ml QOD Sub-Q; Weeks 5-6: Inject 0.1875mg/0.75ml QOD Sub-Q; Weeks 7+: Inject 0.25mg/1ml QOD Sub-Q.	□ 1kit =14vials □ 3kits =14vials	....
□ **Copaxone® or** □ **Glatopa®**	□ 20mg/ml Prefilled Syringe □ 40mg/ml prefilled Syringe	□ Inject 20mg/ml Sub-Q daily. □ Inject 40mg/ml Sub-Q 3 times a week.	□ 1 kit □3 kits □ 12 Syringe) □ 36 Syringes	....
□ **Aubagio®**	□ 7mg □ 14mg	□ Take one 7mg tablet by mouth once a day. □ Take one 14mg tablet by mouth once a day.	□ 1 box □ 3 boxes	....
□ **Gilenya®**	□ 0.5mg Capsule	□ Take one 0.5mg capsule by mouth once daily	□ 1bottle □ 3bottles	....
□ **Rebif®**	□ Titration Pack (Six 8.8mcg & six 22mcg) Prefilled Syringe □ 22 mcg prefilled Syringe □ 44 mcg prefilled syringe □ Titration Pack Rebidose®(six 8.8mcg & six 22mcg) Prefilled Auto injectors. □ Rebidose®22 mcg Prefilled Auto injectors. □ Rebidose®44 mcg Prefilled Auto injectors.	□ Dose Titration for 22mcg:- Week 1-2 Inject 4.4mcg Sub-Q 3 times a week; Weeks 3-4 Inject 11mcg Sub-Q 3 times a week; Weeks 5+ Inject 22mcg Sub-Q 3 times a week. □ Dose Titration for 44mcg:- Week 1-2 Inject 8.8mcg Sub-Q 3 times a week; Weeks 3-4 Inject 22mcg Sub-Q 3 times a week; Weeks 5+ Inject 44mcg Sub-Q 3 times a week.	□ 1kit □ 3kits □________	....
□ **RebiJect® II**		□ Contact qualified health professional before use of Auto injectors.	1	PRN
□ **Tecfidera™**	□ Titration Starter Pack(14 cap of 120mg & 46 cap of 240mg) □ 240mg Capsules □ 120mg Capsules	□ Starter Pack:- 120mg PO twice a day for 7days, then 240mg twice a day. □ Maintenance dose:- Take 240mg cap PO twice a day □________________	□ Starter pack = 30days □ Maintenance Dose (240mg):- □ 30days / □ 90days / □____	....
□ **Plegridy™**	□ Plegridy™(one 63 mcg + one 94mcg) Starter PEN □ Plegridy™(two 125mcg) Pen □ Plegridy™(one 63 mcg + one 94mcg) Starter Prefilled Syringe □ Plegridy™(two 125mcg) Prefilled Syringe	□ Inject 63 mcg Sub-Q on day 1, 94 mcg on day 15, then 125 mcg every 14 days thereafter. □ Other: ____	□ Starter pack 28 days. □ Maintenance Pack 28 days. □ Maintenance Pack 84 days. □ _________	....

HUNTINGTON'S DISEASE

□ **Xenazine®**	□ 12.5mg □ 25mg		....	....
□ **Austedo®**	□ 6mg □ 9mg □ 12mg		....	....

Physician Signature: __________________________ □ **DAW (Dispense as Written) Date:** ________________

Physician Name: ____________________ **Phone:** __________ **Fax:** __________ **Office Contact:** __________

Physician Address: __________________________ **NPI:** ______________ **DEA:** __________

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NEUROLOGY ENROLLMENT FORM: INFUSION

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Social Security No ______________________ Date of Birth ______________________

Sex □ M □ F Weight_______ Height_______ Allergies____________________

Home Phone ______________________ Work/Mobile ______________________

Home Address ______________________

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______________________ Medical Insurance Phone ______________________

Rx Card (PBM) ______________________ Group No ______________________

Prescription Card Bin # ______________________ PCN # ______________________

TREATMENT ARRANGEMENTS

•Start Date:__________________ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Doctor's Office □ Other:_________________________

STATEMENT OF MEDICAL NECESSITY: Diagnosis: □ G35 Multiple Sclerosis -> □ Relapsing/Remitting □ Progressive □_________ Date of Diagnosis:___________

- Is Patient using prescribed therapy in combination with other biologics for MS? □ Yes □ No
- Is Patient pregnant, nursing, or planning pregnancy? □ Yes □ No □ N/A Allergies:____

Tried and failed Medications: ____

HEP-B Test Result: □ Positive □ Negative Date: ______________________

PRESCRIPTION INFORMATION

MEDICATION	DOSE FORM & STRENGTH	DIRECTIONS	QUANTITY	REFILL
□ **Radicava®**	□ 300mg/100ml	□ **Initial Dose:** 60mg IV daily for 14 days followed by 14-days drug free periods. □ **Subsequent Dose:** 60mg IV daily for 10 days out of 14 day periods, followed by 14– day drug free periods x 1 year.	....	....
□ **Ocrevus®**	□ 300mg/10ml	□ **Loading Dose:** 300mg IV at 0 and 2 weeks, □ **Subsequent Dose:** 600 mg IV every 6 months. Protocol Pre-Medication Orders: Solu-Medrol 100mg IV and Anti-Histamine 25 mg PO to be given 30mins before infusion.	....	....
□ **Lemtrada®**	□ 12 mg/1.2ml vial	□ Dose Titration:-Premedicate with corticosteroids. Must be diluted before admin. Day 1 infuse 12mg over 4 hrs.; Day (2 to 5) can infuse 12 mg over 2 hrs., may extend time if patient is not doing well; Admin antiviral agents for herpetic prophylaxis for minimum 2 months.	....	....
□ **Tysabri®**	□ 300mg/15ml	□ 300mg Infused IV over one hour, every 4 weeks. □ Other: ______________________	....	....
□ **Rituxan®**	□ 100mg/10ml □ 500mg/50ml	□ **Loading Dose:** 1000mg IV once and repeat in two weeks. □ **Maintenance Dose:** 1000mg IV once every six months. □ Other: ______________________	....	....
□ **Cyclophosphamide**	□ 800mg/m2	□	....	....

Physician Signature: ______________________ □ **DAW (Dispense as Written) Date:** ______________________

Physician Name: ______________________ **Phone:** ______________________ **Fax:** ______________________ **Office Contact:** ______________________

Physician Address: ______________________ **NPI:** ______________________ **DEA:** ______________________

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