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:** _____

By Signing this prescription and using Southside pharmacy's services you authorize Southside Pharmacy to contact Insurance companies for prior authorization purposes on your behalf.

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