

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
<input type="checkbox"/> Avonex®	<input type="checkbox"/> 30mcg Prefilled Syringe <input type="checkbox"/> 30mcg Single Dose Vial <input type="checkbox"/> 30mcg Avonex Pen	<input type="checkbox"/> Inject 30mcg IM once a week. <input type="checkbox"/> Dose Titration: Week 1 Admin 7.5mcg IM; Week 2 Admin 15mcg IM; Week 3 Admin 22.5mcg IM; Week 4+ Admin 30mcg IM.	<input type="checkbox"/> 1 kit <input type="checkbox"/> 3 kits
<input type="checkbox"/> Betaseron® or <input type="checkbox"/> Extavia®	<input type="checkbox"/> 0.3mg Vial	<input type="checkbox"/> Inject 0.25mg(1ml) Sub-Q every other day. <input type="checkbox"/> 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.	<input type="checkbox"/> 1kit =14vials <input type="checkbox"/> 3kits =14vials
<input type="checkbox"/> Copaxone® or <input type="checkbox"/> Glatopa®	<input type="checkbox"/> 20mg/ml Prefilled Syringe <input type="checkbox"/> 40mg/ml prefilled Syringe	<input type="checkbox"/> Inject 20mg/ml Sub-Q daily. <input type="checkbox"/> Inject 40mg/ml Sub-Q 3 times a week.	<input type="checkbox"/> 1 kit <input type="checkbox"/> 3 kits <input type="checkbox"/> 12 Syringe) <input type="checkbox"/> 36 Syringes
<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"/> 1 box <input type="checkbox"/> 3 boxes
<input type="checkbox"/> Gilenya®	<input type="checkbox"/> 0.5mg Capsule	<input type="checkbox"/> Take one 0.5mg capsule by mouth once daily	<input type="checkbox"/> 1bottle <input type="checkbox"/> 3bottles
<input type="checkbox"/> Rebif®	<input type="checkbox"/> Titration Pack (Six 8.8mcg & six 22mcg) Prefilled Syringe <input type="checkbox"/> 22 mcg prefilled Syringe <input type="checkbox"/> 44 mcg prefilled syringe <input type="checkbox"/> Titration Pack Rebido®(six 8.8mcg & six 22mcg) Prefilled Auto injectors. <input type="checkbox"/> Rebido®22 mcg Prefilled Auto injectors. <input type="checkbox"/> Rebido®44 mcg Prefilled Auto injectors.	<input type="checkbox"/> 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. <input type="checkbox"/> 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.	<input type="checkbox"/> 1kit <input type="checkbox"/> 3kits <input type="checkbox"/> _____
<input type="checkbox"/> Rebiject® II		<input type="checkbox"/> Contact qualified health professional before use of Auto injectors.	1	PRN
<input type="checkbox"/> Tecfidera™	<input type="checkbox"/> Titration Starter Pack(14 cap of 120mg & 46 cap of 240mg) <input type="checkbox"/> 240mg Capsules <input type="checkbox"/> 120mg Capsules	<input type="checkbox"/> Starter Pack:- 120mg PO twice a day for 7days, then 240mg twice a day. <input type="checkbox"/> Maintenance dose:- Take 240mg cap PO twice a day <input type="checkbox"/> _____	<input type="checkbox"/> Starter pack = 30days <input type="checkbox"/> Maintenance Dose (240mg):- <input type="checkbox"/> 30days / <input type="checkbox"/> 90days / <input type="checkbox"/> _____
<input type="checkbox"/> Plegridy™	<input type="checkbox"/> Plegridy™(one 63 mcg + one 94mcg) Starter PEN <input type="checkbox"/> Plegridy™(two 125mcg) Pen <input type="checkbox"/> Plegridy™(one 63 mcg + one 94mcg) Starter Prefilled Syringe <input type="checkbox"/> Plegridy™(two 125mcg) Prefilled Syringe	<input type="checkbox"/> Inject 63 mcg Sub-Q on day 1, 94 mcg on day 15, then 125 mcg every 14 days thereafter. <input type="checkbox"/> Other: _____	<input type="checkbox"/> Starter pack 28 days. <input type="checkbox"/> Maintenance Pack 28 days. <input type="checkbox"/> Maintenance Pack 84 days. <input type="checkbox"/> _____

HUNTINGTON'S DISEASE

<input type="checkbox"/> Xenazine®	<input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg			
<input type="checkbox"/> Austedo®	<input type="checkbox"/> 6mg <input type="checkbox"/> 9mg <input type="checkbox"/> 12mg			

Physician Signature: _____ DAW (Dispense as Written) Date: _____

Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____

Physician Address: _____ NPI: _____ DEA: _____

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 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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