



# VITAL CARE RX

Tailored Therapy, Trusted Care

## Multiple Sclerosis Enrollment Form

Phone: (877)229-1724 | Fax: (877)229-1725

### PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)

Please fax copy of patient's insurance card including both sides

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender: M / F Height: \_\_\_\_\_ Wt: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Last 4 digits SS#: \_\_\_\_\_ Email: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_  
 State Lic. #: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Diagnosis:  340.0 Multiple Sclerosis  Other - \_\_\_\_\_  
 Relapsing - Remitting  Primary - Progressive  Secondary - Progressive  Other - \_\_\_\_\_  
 Allergies - \_\_\_\_\_  
 Previous Meds Used \_\_\_\_\_  
 Weight \_\_\_\_\_ Date Taken \_\_\_\_\_ Other Medications \_\_\_\_\_  
 LEVF \_\_\_\_\_ Date \_\_\_\_\_ Platelets \_\_\_\_\_ Date \_\_\_\_\_ ANC \_\_\_\_\_ Date \_\_\_\_\_  
 Pregnancy Test  Positive  Negative Date taken \_\_\_\_\_ Bilirubin \_\_\_\_\_ Date \_\_\_\_\_

### PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
<b>Ampyra®</b> <input type="checkbox"/> 10 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once a day.	<input type="checkbox"/> 28-day supply (1 kit) <input type="checkbox"/> 84-day supply (3 kits)	
<b>Aubagio®</b> <input type="checkbox"/> 7 mg Tablet <input type="checkbox"/> 14 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once a day.	<input type="checkbox"/> 28-day supply (1 kit) <input type="checkbox"/> 84-day supply (3 kits)	
<b>Avonex®</b> <input type="checkbox"/> 30 mcg Prefilled Syringe <input type="checkbox"/> 30 mcg Single Dose Vial	<input type="checkbox"/> Inject 30 mcg intramuscularly once a week	<input type="checkbox"/> 28-day supply (1 kit) <input type="checkbox"/> 84-day supply (3 kits)	
<b>Betaseron®</b> <input type="checkbox"/> 0.3 mg <input type="checkbox"/> BETAJECT® Lite Autoinjector	<input type="checkbox"/> Inject SQ every other day <input type="checkbox"/> Inject 0.0625 mg (0.25 ml) weeks 1 – 2, inject 0.125 mg (0.5 ml) weeks 3 – 4, inject 0.1875 mg (0.75 ml) weeks 5 – 6 <input type="checkbox"/> Use as directed for BETAJECT®	<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"/> Other -	
<b>Copaxone®</b> <input type="checkbox"/> 20 mg Prefilled Syringe <input type="checkbox"/> Autoject® 2 for glass syringe injection device	<input type="checkbox"/> Inject SQ daily <input type="checkbox"/> Use as directed	<input type="checkbox"/> 30 day supply (1 kit) <input type="checkbox"/> 90 day supply (3 kits) <input type="checkbox"/> Other -	
<b>Extavia®</b> <input type="checkbox"/> 0.3 mg	<input type="checkbox"/> Inject SQ every other day <input type="checkbox"/> Inject 0.0625 mg (0.25 ml) weeks 1 – 2, inject 0.125 mg (0.5 ml) weeks 3 – 4, inject 0.1875 mg (0.75 ml) weeks 5 – 6	2 week supply	
<b>Gilenya®</b> <input type="checkbox"/> 0.5 mg capsules	<input type="checkbox"/> Take one capsule by mouth daily	<input type="checkbox"/> 30 day supply	
<b>Glatopa®</b> <input type="checkbox"/> 20 mg Syringe	<input type="checkbox"/> Inject 20 mg subcutaneously daily.	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits)	
<b>Novantrone®</b> <input type="checkbox"/> 10 mg/5ml multidose vial <input type="checkbox"/> 20 mg/10ml multidose vial	<input type="checkbox"/> Dilute and administer 12mg/m2 as IV infusion every 3 months <input type="checkbox"/> Other -	<input type="checkbox"/> Lifetime cumulative dose (Max life time dose of 140 mg/2)	
<b>Ocrevus®</b> 300 mg/10 ml single dose vial	<input type="checkbox"/> Induction: Infuse 300 mg IV over approximately 2.5 hours. Follow with a second 300 mg IV infusion over approximately 2.5 hours two weeks later. Infusions may be interrupted or slowed as needed. <input type="checkbox"/> Maintenance: Infuse 600 mg IV over approximately 3.5 hours every 6 months. Infusions may be interrupted or slowed as needed.	<input type="checkbox"/> 2 vials <input type="checkbox"/> Other -	
<b>Rebif®</b> <input type="checkbox"/> Triton Pack (six 8.8 mcg & six 22 mcg prefilled syringes) <input type="checkbox"/> 22 mcg prefilled syringe <input type="checkbox"/> 44 mcg prefilled syringe <input type="checkbox"/> Rebiject®	<input type="checkbox"/> Inject 8.8 mcg SQ three times a week on weeks 1 – 2, 22mcg SQ three times a week on weeks 3 – 4, and 44mcg SQ three times a week on weeks 5 + <input type="checkbox"/> Inject SQ three times a week <input type="checkbox"/> Inject SQ 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 -	
<b>Tecfidera®</b> <input type="checkbox"/> 30-Day Starter Pack <input type="checkbox"/> 120mg Capsule <input type="checkbox"/> 240mg Capsule	Take one 120 mg capsule by mouth twice a day for 7 days, followed by one 240 mg capsule by mouth twice a day	<input type="checkbox"/> 30 day supply	
	<input type="checkbox"/> Take 240 mg by mouth twice a day. <input type="checkbox"/> Other _____	<input type="checkbox"/> 7-day supply <input type="checkbox"/> 28-day supply (1 kit) <input type="checkbox"/> 84-day supply (3 kits)	

Ship Medications To:  Physician's Clinic  Patient's Home

Injection Training Needed:  Yes  No

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Brand Name Required?  Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.