vitalcare SPECIALTY

VITAL CARE RX
Multiple Sclerosis Enrollment Form

Phone: (877)229-1724 I 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: 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
Ampyra®	☐ 10 mg Tablet	☐ Take one tablet by mouth once a day.	☐ 28-day supply (1 kit) ☐ 84-day supply (3 kits)	
Aubagio®	☐ 7 mg Tablet ☐ 14 mg Tablet	☐ Take one tablet by mouth once a day.	☐ 28-day supply (1 kit) ☐ 84-day supply (3 kits)	
Avonex®	☐ 30 mcg Prefilled Syringe ☐ 30 mcg Single Dose Vial	☐ Inject 30 mcg intramuscularly once a week	☐ 28-day supply (1 kit) ☐ 84-day supply (3 kits)	
Betaseron®	☐ 0.3 mg ☐ BETAJECT® Lite Autoinjector	☐ Inject SQ every other day ☐ 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 ☐ Use as directed for BETAJECT®	☐ 28 day supply (1 kit of 14 vials) ☐ 84 day supply (3 kits of 14 vials) ☐ Other -	
Copaxone®	☐ 20 mg Prefilled Syringe ☐ Autoject® 2 for glass syringe injection device	☐ Inject SQ daily ☐ Use as directed	☐ 30 day supply (1 kit) ☐ 90 day supply (3 kits) ☐ Other -	
Extavia®	☐ 0.3 mg	☐ Inject SQ every other day ☐ 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	
Gilenya®	☐ 0.5 mg capsules	☐ Take one capsule by mouth daily	☐ 30 day supply	
Glatopa®	☐ 20 mg Syringe	☐ Inject 20 mg subcutaneously daily.	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits)	
Novantrone®	☐ 10 mg/5ml multidose vial ☐ 20 mg/10ml multidose vial	☐ Dilute and administer 12mg/m2 as IV infusion every 3 months ☐ Other -	☐ Lifetime cumulative dose (Max life time dose of 140 mg/2)	
Ocrevus®	300 mg/10 ml single dose vial	☐ 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. ☐ Maintenance: Infuse 600 mg IV over approximately 3.5 hours every 6 months. Infusions may be interrupted or slowed as needed.	☐ 2 vials ☐ Other -	
Rebif®	☐ Tritration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) ☐ 22 mcg prefilled syringe ☐ 44 mcg prefilled syringe ☐ Rebiject®	☐ Inject 8.8 mcg SQ three times a week on weeks 1 – 2 then 22mcg SQ three times a week on weeks 3-4. ☐ Inject SQ three times a week ☐ Inject SQ three times a week ☐ Other -	☐ 4 week supply (1 kit) ☐ 12 week supply (3 kits) ☐ Other -	
Tecfidera®	☐ 30-Day Starter Pack ☐ 120mg Capsule ☐ 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	☐ 30 day supply	
		☐ Take 240 mg by mouth twice a day. ☐ Other _____	☐ 7-day supply ☐ 28-day supply (1 kit) ☐ 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.