Multiple Sclerosis Enrollment Form – Injectables

Phone: 800-476-7496
Fax: 888-985-9223

Since 1933 Boothwyn Pharmacy

PATIENT INFORMATION (PLEASE PRINT)				
Patient Name (Last, First, Mi)			☐ Male ☐ Female	
Date of Birth (mm/dd/yyyy)	SS#	Phone (Daytime)	Phone (Evening)	
Street Address (Please include Suite/Apt Number)		City	State	Zip

INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT'S PHARMACY BENEFIT CARD - FRONT AND BACK)		
Primary Insurance		Policy Holder
Policy #	Group #	Phone

DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)			
☐ 340 Multiple Sclerosis	☐ Other ICD9 _____	Is patient new to therapy? ☐ yes ☐ no	Date of Diagnosis: Date of first demyelinating event:

Type: ☐ Relapsing-remitting ☐ Secondary progressive with relapses ☐ Primary progressive
☐ Secondary progressive without relapses ☐ Clinically Isolated Syndrome (CIS) ☐ Progressive-relapsing

Patient Weight: _____ kg. OR _____ lbs.	Drug Allergies: _____ ☐ NKDA

PREVIOUS MEDICATIONS (Please specify dosage and time on therapy)		
Medication Strength and Dose	*Date of Therapy*	*Reason for Discontinuing*

PRESCRIPTION INFORMATION				
Rx-Medication	*Strength*	*Dose and Frequency*	*Quantity*	*Refills*
☐ **Avonex**	☐ 30 mcg Prefilled Syringe ☐ 30 mcg Single Dose Vial ☐ 30 Avonex Pen (single dose)	☐ Inject 30 mcg intramuscularly once a week	☐ 4 week supply – 1 kit ☐ 12 week supply – 3 kits	
☐ **Betaseron**	☐ 0.3 mg	☐ Inject 0.25 mg (1ml) subcutaneously every other day ☐ Dose Titration: Weeks 1-2: 0.0625 mg (0.25ml) subcutaneously QOD Weeks 3-4: 0.125 mg (0.50ml) subcutaneously QOD Weeks 5-6: 0.1875 mg (0.75ml) subcutaneously QOD Weeks 7+: 0.25 mg (1ml) subcutaneously QOD ☐ Other _____	☐ 28 day supply 1 kit of 14 vials ☐ 84 day supply 3 kits of 14 vials ☐ Other _____	
	☐ BETAJECT Lite Autoinjector	☐ Use as Directed	☐_____	
☐ **Copaxone**	☐ 20 mg Prefilled Syringe	☐ Inject 20 mg subcutaneously daily	☐ 30 day supply ☐ 90 day supply	
	☐ Autoject 2			
☐ **Extavia**	☐ 0.3 mg	☐ Inject 0.25 mg (1ml) subcutaneously every other day ☐ Dose Titration: Weeks 1-2: 0.0625 mg (0.25ml) subcutaneously QOD Weeks 3-4: 0.125 mg (0.50ml) subcutaneously QOD Weeks 5-6: 0.1875 mg (0.75ml) subcutaneously QOD Weeks 7+: 0.25 mg (1ml) subcutaneously QOD ☐ Other _____	☐ 30 day supply - 1 kit ☐ 90 day supply – 3 kits	
	☐ EXTAVIA Auto Injector II	☐ Use as Directed	☐_____	

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS
☐ Patient's Home ☐ Physician's Office Date Needed: ____/____/_____ Patient needs Education Kit? ☐ yes ☐ no

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION			
Physician Name	License #	DEA #	UPIN #
Office Contact	Phone	Fax	NPI#
Street Address (Please include Suite Number)	City/State/Zip		
Physician's Signature	Date (required)		
This prescription will be filled generically unless Prescriber writes "DAW" in the box to the right.			