Multiple Sclerosis Enrollment Form – ORAL Medications

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*
☐ **Gilenya**	☐ 0.5 mg	☐ Take one capsule by mouth once daily ☐ Other _____	☐ 1 box – 28 capsules	
☐ **Aubagio**	☐ 14 mg ☐ 7 mg	☐ Take one capsule by mouth once daily ☐ Other _____	☐ 1 box – 28 capsules	
☐ **Tecfidera**	☐ Starter Pack	☐ Take one 120 mg capsule by mouth twice daily for 7 days; then one 240 mg capsule by mouth twice daily there after	☐ Starter Pack 14 120 mg caps and 46 240 mg caps	
	☐ 240 mg	☐ Take one capsule by mouth twice daily ☐ Other _____	☐ 60 caps – 30 day supply ☐ Other _____	
	☐ 120 mg	☐ Take one capsule by mouth twice daily ☐ Other _____	☐ 14 caps – 7 day supply ☐ Other _____	

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

Teaching to be done at:	☐ Patient's Home	
	☐ Physician's Office	☐ Not needed

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. ☐