Multiple Sclerosis (A-E) Enrollment Form

(Aubagio®, Avonex®, Betaseron®, Copaxone®, Extavia®)

Fax Referral To: 207-899-0968
Address: 141 Preble St. Portland, ME 04101
Phone: 877-814-8447
NCPDP: 2008301

Six Simple Steps to Submitting a Referral

❶PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____
Address: _____
City, State, ZIP: _____
Preferred Contact Method: ☐Phone (to primary # provided below) ☐Text (to cell # provided below) ☐Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
Email: _____
Last Four of SSN: _____ Primary Language: _____

❷PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact's Phone: _____

❸INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

❹DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____

Ship to: ☐ Patient ☐ Prescriber's Office ☐ Coram® Ambulatory Infusion Suite ☐ Other _____
☐ Infusion Site: Name _____ Address: _____ *(Please include street address, suite #, city, state, zip)*

Diagnosis (ICD-10):
☐ G35 Multiple Sclerosis (MS) ☐ Code: _____ Description: _____ (For additional ICD-10 information, please visit www.CVSspecialty.com/ICD10)

If MS, please indicate type:
☐ Primary progressive MS (PPMS) ☐ Relapsing-remitting MS (RRMS) ☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No

Height: _____ inches/cm Weight: _____lbs/kg Allergies: _____
Has pregnancy been excluded? ☐ Yes ☐ No ☐ Not applicable (e.g., male, post-menopause)

For Gilenya: Please provide the patient's QTc interval: _____ms ☐ Unknown Is the patient currently receiving therapy with Gilenya? ☐ Yes ☐ No

MS drug(s) not able to use:

Drug: _____ ☐Inadequate response, trial duration _____ ☐Intolerance, specify: _____ ☐Contraindication, specify: _____
Drug: _____ ☐Inadequate response, trial duration _____ ☐Intolerance, specify: _____ ☐Contraindication, specify: _____

Nursing and Administration: Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Place of Infusion: ☐ Coram Ambulatory Infusion Suite ☐ Prescriber's Office ☐ Infusion site above

❺PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Aubagio	☐ 7 mg ☐ 14 mg	☐ Take one tablet by mouth once a day.	☐ 28-day supply (1 box) ☐ 84-day supply (3 boxes)	
☐ Avonex	☐ 30 mcg prefilled syringe ☐ 30 mcg pen (single doses) ☐ 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	☐ Inject 0.25 mg (1mL) subcutaneously every other day. ☐ Dose Titration: • Weeks 1-2: Inject 0.0625 mg/0.25 mL subcutaneously QOD; • Weeks 3-4: Inject 0.125 mg/0.50 mL subcutaneously QOD; • Weeks 5-6: Inject 0.1875 mg/0.75 mL subcutaneously QOD; • Weeks 7+: Inject 0.25 mg/1 mL subcutaneously QOD ☐ Other _____	☐ 28-day supply (1 kit of 14 vials) ☐ 84-day supply (3 kits of 14 vials)	
☐ BETAJECT® Lite Autoinjector		Use as directed.	1	PRN
☐ Copaxone	☐ 20 mg prefilled syringe	Inject 20 mg subcutaneously daily.	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits)	
☐ May Substitute	☐ 40 mg prefilled syringe	Inject 40 mg subcutaneously three times a week.	☐ 28-day supply (12 syringes) ☐ 84-day supply (36 syringes)	
☐ Autoject® 2 for glass syringe injection device		Use as directed.	1	PRN
☐ Extavia	0.3 mg	☐ Inject 0.25 mg (1 mL) subcutaneously every other day. ☐ Dose Titration: • Weeks 1-2: Inject 0.0625 mg/0.25 mL subcutaneously QOD • Weeks 3-4: Inject 0.125 mg/0.50 mL subcutaneously QOD • Weeks 5-6: Inject 0.1875 mg/0.75 mL subcutaneously QOD • Weeks 7+: Inject 0.25 mg/1 mL subcutaneously QOD ☐ Other _____	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits)	
☐ EXTAVIA Auto-Injector II		Use as directed.	1	PRN

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

❻X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED

X _____ (Date)
DISPENSE AS WRITTEN

Multiple Sclerosis (F-O) Enrollment Form

(Gilenya®, Glatiramer Acetate, Glatopa™, Lemtrada®, Ocrevus™)

Fax Referral To: 207-899-0968
Address: 141 Preble St. Portland, ME 04101
Phone: 877-814-8447
NCPDP: 2008301

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Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
Email: _____
Last Four of SSN: _____ Primary Language: _____

❷PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact's Phone: _____

❸INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

❹DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____

Ship to: ☐ Patient ☐ Prescriber's Office ☐ Coram Ambulatory Infusion Site ☐ Other _____
☐ Infusion Site: Name _____ Address: _____ *(Please include street address, suite #, city, state, zip)*

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☐ Primary progressive MS (PPMS) ☐ Relapsing-remitting MS (RRMS) ☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No

Height: _____ inches/cm Weight: _____lbs/kg Allergies: _____

MS drug(s) not able to use:

Drug: _____
☐Inadequate response, trial duration _____
☐Intolerance, specify: _____
☐Contraindication, specify: _____

Drug: _____
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☐Intolerance, specify: _____
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Nursing and Administration: Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Place of Infusion: ☐ Coram Ambulatory Infusion Site ☐ Prescriber's Office ☐ Infusion site above

❺PRESCRIPTION INFORMATION

MEDICATION/DOSE/STRENGTH		DIRECTIONS	QUANTITY	REFILLS
☐ Gilenya	0.5 mg	Take one capsule by mouth once daily.	☐ 30-day supply (1 bottle) ☐ 90-day supply (3 bottles)	
☐ Glatiramer Acetate 40 mg prefilled syringe		Inject 40 mg subcutaneously three times a week.	☐ 28-day supply (12 syringes) ☐ 84-day supply (36 syringes)	
☐ WhisperJECT Autoinjector device (1st fill only)		Use as directed.	1	0
☐ Welcome Kit (1st fill only)		Use as directed.	1	0
☐ Glatopa	20 mg prefilled syringe	Inject 20 mg subcutaneously daily.	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits)	
☐ Lemtrada	Please complete an MS One to One®/Lemtrada enrollment form and indicate CVS Specialty™ as your preferred pharmacy provider. (For questions, please contact MS One to One at 1-855-676-6326).			
Please use the following toll-free fax/phone numbers for Ocrevus enrollments. Fax: 1-844-847-8585; Phone: 1-855-821-0356.				
☐ Ocrevus 300 mg/10 mL (30 mg/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 ☐ _____	
Diluent: ☐ Sodium Chloride 0.9%			☐ 250 mL (induction) ☐ 500 mL (maintenance)	
Premedication Corticosteroid: ☐ Methylprednisolone ____ mg ☐ _____		☐ 100mg administered IV approximately 30 minutes prior to each Ocrevus™ infusion. ☐ _____		
Premedication Antihistamine: ☐ Diphenhydramine _____ mg ☐ _____				

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

❻X _____ PHYSICIAN SIGNATURE REQUIRED X _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

75-40946A 032318

Multiple Sclerosis (P-Z) Enrollment Form

(Plegridy®, Rebif®, Ribiject II®, Tecfidera®, Tysabri®)

Fax Referral To: 207-899-0968
Address: 141 Preble St. Portland, ME 04101
Phone: 877-814-8447
NCPDP: 2008301

Six Simple Steps to Submitting a Referral

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Patient Name: _____
Address: _____
City, State, ZIP: _____
Preferred Contact Method: ☐Phone (to primary # provided below) ☐Text (to cell # provided below) ☐Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
Email: _____
Last Four of SSN: _____ Primary Language: _____

❷PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact's Phone: _____

❸INSURANCE INFORMATION

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❹DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____

Ship to: ☐ Patient ☐ Prescriber's Office ☐ Coram® Ambulatory Infusion Suite ☐ Other _____
☐ Infusion Site: Name _____ Address: _____ *(Please include street address, suite #, city, state, zip)*

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☐ Primary progressive MS (PPMS) ☐ Relapsing-remitting MS (RRMS) ☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No

Height: _____ inches/cm Weight: _____lbs/kg Allergies: _____
Has pregnancy been excluded? ☐ Yes ☐ No ☐ Not applicable (e.g., male, post-menopause)

For Gilenya: Please provide the patient's QTc interval: _____ms ☐ Unknown Is the patient currently receiving therapy with Gilenya? ☐ Yes ☐ No

MS drug(s) not able to use:

Drug: _____
☐Inadequate response, trial duration _____
☐Intolerance, specify: _____
☐Contraindication, specify: _____

Drug: _____
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Nursing and Administration: Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Place of Infusion: ☐ Coram Ambulatory Infusion Suite ☐ Prescriber's Office ☐ Infusion site above

❺PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Plegridy	☐ Pen Starter Pack (one 63 mcg pen & one 94 mcg pen) ☐ Pre-Filled Syringe Starter Pack (one 63 mcg pre-filled syringe & one 94 mcg pre-filled syringe)	Day 1: Administer 63 mcg/0.5mL subcutaneously; Day 15: Administer 94 mcg/0.5 mL subcutaneously	28-day supply	
	☐ Pen Maintenance Pack (two 125 mcg pens) ☐ Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes)	☐ Administer 125 mcg/0.5 mL subcutaneously every 14 days. ☐ Other _____	☐ 28-day supply (1 pk) ☐ 84-day supply (3 pks)	
☐ Rebif	☐ Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) ☐ Rebidose® Titration Pack (six 8.8 mcg prefilled autoinjectors & six 22 mcg prefilled autoinjectors)	Weeks 1-2: Inject 8.8 mcg subcutaneously three times a week Weeks 3-4: Inject 22 mcg subcutaneously three times a week	28-day supply (1 kit)	
	☐ 22 mcg prefilled syringe ☐ 44 mcg prefilled syringe ☐ Rebidose 22 mcg prefilled autoinjector ☐ Rebidose 44 mcg prefilled autoinjector	☐ Inject 44 mcg subcutaneously three times a week. ☐ Other _____	☐ 28-day supply (1 kit) ☐ 84-day supply (3 kits)	
☐ Rebiject II		Use as directed.	1	PRN
☐ Tecfidera	☐ Titration Starter Pack (14 capsules of 120 mg & 46 capsules of 240 mg)	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	
	☐ 120 mg capsules ☐ 240 mg capsules	☐ Take 240 mg by mouth twice a day. ☐ Other _____	☐ 7-day supply ☐ 30-day supply ☐ 90-day supply	
☐ Tysabri	Please complete an MS Touch®/Tysabri enrollment form and indicate CVS Specialty™ as your preferred pharmacy. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255).			

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

❻X _____ PHYSICIAN SIGNATURE REQUIRED
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)