elixir
SPECIALTY PHARMACY

Multiple Sclerosis Injectable Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ____________________
Date of Birth: __________ Gender: _________ Last four of SSN: ________
Address: ____________________
City: ____________ State: ________ Zip: ____________
Home Phone: ____________ Work Phone: ____________
Cell Phone: ____________ E-mail: ____________
Patient Weight: ____________ kg/lbs Patient Height: ____________ in/cm
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ____________________
Insurance Company Phone: ____________________
Policy holder: ____________________
Policy holder Employer: ____________________
Relationship to Patient: ____________________
ID# ____________ Group# ____________
RxBIN: ____________ RxPCN: ____________

Prescriber Information

Practice/ Organization Name: ____________________
Physician Name: ____________________
Contact Person: ____________ Contact's Phone: ____________
Address: ____________________
City: ____________ State: ____________ Zip: ____________
Office Phone#: ____________ Office Fax#: ____________
DEA# ____________ NPI# ____________
License#: ____________ Medicaid UPIN#: ____________
Physician Specialty: ____________________
Date Shipment Needed: ____________________
Ship to: ☐Patient ☐Prescriber ☐Other ____________
Shipment Address: ____________ Attn: ____________
City: ____________ State: ____________ Zip: ____________
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Diagnosis and Clinical Information

Diagnosis (ICD-10): ☐ G35 Multiple Sclerosis ☐ Other Code: ____________ Description ____________
If MS, please indicate type: ☐ Primary progressive MS (PPMS) ☐ Relapsing-remitting MS (RRMS) ☐ Progressive-relapsing MS ☐ Secondary progressive MS (SPMS)
☐ Clinically Isolated Syndrome
Date of Diagnosis or Years with Disease: ____________________
Previous failed therapies, discontinuation reasons and dates:

Therapy	Discontinuation Reason	Dates

Patient Allergies: ____________________ Latex allergy: ☐Yes ☐No
Comorbidities: ____________________
Has pregnancy been excluded? ☐Yes ☐No ☐ Not applicable (e.g., male, post-menopause)
Has the patient had a NEGATIVE tuberculin test? ☐Yes ☐No If yes, date of test: __________
☐ **First dose observation complete if applicable:** __________ ☐ **First dose observation completion date:** ____________

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.

elixir SPECIALTY PHARMACY

Multiple Sclerosis (Injectable) Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Name: ______________________ **Patient Date of Birth:** ______________________

Prescriber Name: ______________________ **Phone:** ______________ **Date:** ______________

Prescriber Address: ____

Medication	Strength	Directions	Quantity/Refills
☐ **Avonex®** ☐ Pen ☐ PFS	30mcg	☐ Initial titration: Inject IM as follows: 7.5mcg on week 1; 15mcg IM on week 2; 22.5mcg IM on week 3; then 30mcg IM on week 4 and once weekly thereafter. Dispense PFS with AVOSTARTGRIP™ Titration device. ☐ Inject 30mcg IM once a week	Quantity: Refills (maint only):
☐ **Betaseron®** ☐ **Extavia®**	0.3mg/vial	☐ Initial titration: • Weeks 1-2: Inject 62.5mcg SQ every other day • Weeks 3-4: Inject 125mcg SQ every other day • Weeks 5-6: Inject 187.5mcg SQ every other day • Week 7+: Inject 250mcg SQ every other day ☐ Inject 250mcg SQ every other day	Quantity: Refills (maint only):
☐ **Copaxone®** ☐ **Glatiramer acetate** ☐ **Glatopa®**	☐ 20mg ☐ 40mg	☐ Inject 20mg SQ once daily. ☐ Inject 40mg SQ three times weekly	Quantity: Refills:
☐ **Kesimpta®**	20mg	☐ Initial titration: Inject 20mg SQ at week 0,1, and 2 ☐ Inject 20mg SQ at week 4, then every 4 weeks thereafter	Quantity: Refills (maint only):
☐ **Plegridy® (subcutaneous administration)** ☐ Pen ☐ PFS	☐ Starter kit (SQ) ☐ 125mcg (SQ)	☐ Initial titration: Inject 63mcg SQ on day 1, inject 94mcg on day 15 and inject 125mcg every 14 days thereafter ☐ Inject 125mcg SQ every 14 days	Quantity: Refills (maint only):
☐ **Plegridy® (intramuscular administration)** ☐ PFS	☐ 125mcg (IM)	☐ Initial titration: Inject 63mcg IM on day 1, inject 94mcg on day 15 and inject 125mcg every 14 days thereafter ☐ Inject 125mcg IM every 14 days	Quantity: Refills (maint only):
☐ **Rebif®** ☐ Rebidose ☐ PFS	☐ Titration pack ☐ 22mcg ☐ 44mcg	☐ Initial titration (for 44mcg maint dosing): • Weeks 1-2: Inject 8.8mcg SQ three times weekly • Weeks 3-4: Inject 22mcg SQ three times weekly • Weeks 5+: Inject 44mcg SQ three times weekly ☐ Inject 22mcg SQ three times weekly ☐ Inject 44mcg SQ three times weekly	Quantity: Refills (maint only):

Prescriber Signature: *X*______________________ **Date:** ______________________

If Brand required "Dispense as Written" must be handwritten

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.