elixir SPECIALTY PHARMACY

Multiple Sclerosis Oral 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:**____________________

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☐ New to Therapy
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Patient Name: ________________________ **Patient Date of Birth:** ____________________

Prescriber Name: ________________________ **Phone:** ______________ **Date:** ______________

Prescriber Address: ____

Medication	Strength	Directions	Quantity/Refills
☐ **Aubagio® (teriflunomide)**	☐ 7mg ☐ 14mg	Take one tablet by mouth daily	Quantity: Refills:
☐ **Dalfampridine**	ER 10mg	Take one tablet by mouth twice daily approximately 12 hours apart	Quantity: Refills:
☐ **Gilenya® (fingolimod)** *indicate FDO status above	☐ 0.25mg ☐ 0.5mg	Take one capsule by mouth daily.	Quantity: Refills:
☐ **Mayzent®** *(Patients to be titrated to a 1mg maintenance dose)* *indicate FDO status above	☐ 1mg 5 day starter pack ☐ 1mg ☐ 0.25mg	☐ Initial titration (0.25mg tablets only): Take dose by mouth once daily: 1 tab (0.25mg) on days 1 and 2, 2 tabs (0.5mg) on day 3, 3 tabs (0.75mg) on day 4, 4 tabs (1mg) on day 5 and after ☐ Take 1mg PO once daily ☐ Other:	Quantity: Refills (maint only):
☐ **Mayzent®** *(Patients to be titrated to a 2mg maintenance dose)* *indicate FDO status above	☐ 2mg 5 day starter pack ☐ 2mg	☐ Initial titration (5 day starter pack): Take dose by mouth once daily: 1 tablet on days 1 and 2, 2 tablets on day 3, 3 tablets on day 4, 5 tablets on day 5 ☐ Take one tablet (2mg) PO once daily ☐ Other:	Quantity: Refills (maint only):
☐ **Tecfidera® (dimethyl fumurate)**	☐ Starter Pack ☐ 120mg ☐ 240mg	☐ Initial titration: Take one capsule (120mg) PO twice daily for 7 days, then take 1 capsule (240mg) PO twice daily ☐ Take one capsule (240mg) by mouth twice daily ☐ Other:	Quantity: Refills (maint only):
☐ **Vumerity®**	☐ 231mg	☐ Initial titration: Take one capsule (231 mg) PO twice daily for 7 days, then take 2 capsules (462mg) po twice daily ☐ Take two capsules (462mg) PO twice daily	Quantity: Refills (maint only):
☐ **Zeposia®**	☐ Starter pack (28 day) ☐ 0.92mg	☐ Initial titration: Take 0.23mg PO once daily on days 1-4, 0.46mg PO once daily on days 5-7, 0.92mg po once daily on day 8 and after ☐ Take one capsule (0.92mg) my mouth daily	Quantity: Refills (maint only):

Prescriber Signature: *X*______________________________ **Date:** ____________________

If Brand required "Dispense as Written" must be handwritten

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