elixir
SPECIALTY PHARMACY

Multiple Sclerosis Enrollment Form
Phone: 1-877-437-9012 Fax 1-877-309-0687

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer Name: _____
Date of Birth: __/__/____ Sex: M or F SS#_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of customer's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policyholder:_____
Policy holder Employer:_____
Relationship to Customer:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____

Prescriber Information

Practice/ Organization Name: _____
Physician Name:_____
Address:_____
City: _____State: _____Zip: _____
Phone#:_____Fax#:_____
DEA#_____NPI#_____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____
Date Shipment Needed: __/___/_____ Attn: _____
Ship to: ☐Patient ☐Prescriber ☐Infusion Clinic
Shipment Address: _____
City: _____State: _____Zip:_____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis: ☐G35 Multiple Sclerosis ☐Other:_____
Type: ☐RRMS ☐PPMS ☐SPMS ☐PRMS ☐Clinically definite MS
Date of Diagnosis or Years with Disease: _____ Patients Allergies:_____
Patient Weight: _____ kgs or lbs (*please indicate*) Patient Height: _____ inches or cm. (*please indicate*)
Prior Treatments with duration and reason for discontinuation _____

☐ **Aubagio® (teriflunomide)** ☐ 7 mg ☐ 14 mg One tablet by mouth once daily

☐ **Avonex® (interferon -β1a) Please indicate dosage form:** ☐**Pen** ☐**Prefilled Syringe** ☐ **Single Dose Vials**
☐ 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

☐ **Betaseron® (interferon-β1b)** ☐ Initial titration: 62.5mcg increasing to 250 mcg SC every other day over 6 weeks as directed
☐ Inject 250mcg SC every other day

☐ **Dalfampridine (generic for Ampyra®)** 10 mg tablet by mouth every 12 hours

☐ **Extavia® (interferon-β1b)** ☐ Initial titration: 62.5mcg increasing to 250 mcg SC every other day over 6 weeks as directed
☐ Inject 250mcg SC every other day

☐ **Gilenya® (fingolimod)** ☐ 0.5mg ☐0.25 mg Take 1 capsule by mouth once daily Date of First Dose Observation: ___/___/_____

☐ **Glatiramer acetate OR** ☐ **Copaxone® OR** ☐ **Glatopa®** ☐ Inject 40mg SC three times weekly **OR** ☐ Inject 20mg SC daily

☐ **Mayzent® (siponimod)** *Please note: Elixir Specialty proudly services Mayzent patients but Novartis AlongsideMS requires all initial referrals to route through www.mayzent.com or 877-MAYZENT (629-9368)

☐ **Novantrone® (mitoxantrone)** 12 mg/m2 IV every 3 months.

☐ **Ocrevus® (ocrelizumab)** ☐ Initial titration: 300 mg IV infusion as a single dose, followed by a 2nd 300 mg IV infusion 2 weeks later
☐ Subsequent infusions: 600 mg IV infusion every 6 months (1st dose due 6 months after infusion 1 of the initial dose)

☐ **Plegridy® (pegylated interferon-β1b) Please indicate dosage form:** ☐ **Pen** ☐ **Prefilled Syringe**
☐ Starter Kit Needed: Inject 63mcg SC on day 1, 94mcg on day 15, then 125mcg every 14 days thereafter
☐ Inject 125mcg SC every 14 days

☐ **Rebif® (interferon-β1a) Please indicate dosage form:** ☐ Prefilled Syringe ☐ Rebidose
☐ Titration to 22mcg: Inject SC as follows: 4.4mcg 3X/wk on weeks 1 & 2; 11mcg 3X/wk on weeks 3 & 4; then 22mcg 3x/wk
☐ Titration to 44mcg: Inject SC as follows: 8.8mcg 3X/wk on weeks 1 & 2; 22mcg 3X/wk on weeks 3 & 4; then 44mcg 3x/wk
☐Inject: ☐ 22mcg ☐ 44mcg SC 3 times weekly

☐ **Tecfidera® (dimethyl fumarate)** ☐ Starter Pack: Take 120mg orally twice a day for 7 days, then 240mg twice a day thereafter
☐ Take 1 capsule (240mg) orally twice daily ☐ Other: _____

☐ **Vumerity® (diroximel fumarate)** ☐ Starter Pack: Take 231mg orally twice a day for 7 days, then 462mg twice a day thereafter
☐ Take 2 capsules (462mg) orally twice daily ☐ Other: _____

Lemtrada® (alemtuzumab) to order please call MS One to One at 855-676-6326
Mavenclad® (cladribine) to order please call MS LifeLines at 877-447-3243
Tysabri® (natalizumab) to order Tysabri please call the TOUCH program at 800-456-2255

Quantity Prescribed: ☐ QS 30 days ☐ Other: _____ **Refills Authorized**: ☐ 0 ☐ 1 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____

X_____ Date _____/_____/_____
Physician Signature (no stamps) For No Substitution allowed, please indicate "DAW" here: _____