



# Multiple Sclerosis Enrollment Form G-M

Date: \_\_\_\_\_

Patient Data

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs \_\_\_\_\_ kg \_\_\_\_\_  
 SSN #: XXX-XX-\_\_\_\_ Known Allergies: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Alternate Caregiver Name: \_\_\_\_\_ Phone of Caregiver: \_\_\_\_\_

Ins. Data

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Policy: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy: \_\_\_\_\_ Group#: \_\_\_\_\_

Clinical Information

Diagnosis:  G35 Multiple Sclerosis  Other: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_  
 Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Type:  Relapsing-Remitting  Secondary progressive with relapses  Primary progressive  Secondary progressive without relapses  
 Clinically-Isolated Syndrome (CIS)  Progressive-relapsing  
 Number of Relapses in the Past Year: \_\_\_\_\_ Date of Last MRI: \_\_\_\_/\_\_\_\_/\_\_\_\_ MRI Changes  Yes  No  
 Has patient been previously treated for this condition?  Yes  No  
 If yes, medication/therapy failed (length of therapy): \_\_\_\_\_

Prescription

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Gilenya®	0.5mg capsule	Take one capsule orally once daily	#30	
<input type="checkbox"/> Glatiramer Acetate	<input type="checkbox"/> 20mg PFS	Inject 1 syringe (20mg) subcutaneously once daily	#30	
	<input type="checkbox"/> 40mg PFS	Inject 1 syringe (40mg) subcutaneously 3 times weekly	#12	
<input type="checkbox"/> Glatopa®	<input type="checkbox"/> 20mg PFS	Inject 1 syringe (20mg) subcutaneously once daily	#30	
	<input type="checkbox"/> 40mg PFS	Inject 1 syringe (40mg) subcutaneously 3 times weekly	#12	
<input type="checkbox"/> Kesimpta®	<input type="checkbox"/> 20mg Pen	<input type="checkbox"/> Induction: Inject 20mg subcutaneously at week 0, 1, and 2	#3	0 refills
	<input type="checkbox"/> 20mg PFS	<input type="checkbox"/> Maintenance: Inject 20mg subcutaneously once monthly starting at week 4	#1	
<input type="checkbox"/> Mayzent®	<input type="checkbox"/> 0.25mg tablet	<input type="checkbox"/> Induction to 1mg Dosage: Day 1: Take 1 tablet orally once daily Day 2: Take 1 tablet orally once daily Day 3: Take 2 tablets (0.5mg) orally once daily Day 4: Take 3 tablets (0.75mg) orally once daily	#7	0 refills
		<input type="checkbox"/> Maintenance: Take 4 tablets (1mg) orally once daily	#112	
	<input type="checkbox"/> 0.25mg tablet Starter pack <input type="checkbox"/> 2mg tablet	<input type="checkbox"/> Induction to 2mg Dosage: Day 1: Take 1 tablet orally once daily Day 2: Take 1 tablet orally once daily Day 3: Take 2 tablets (0.5mg) orally once daily Day 4: Take 3 tablets (0.75mg) orally once daily Day 5: Take 5 tablets (1.25mg) orally once daily	#1 pack	0 refills
		<input type="checkbox"/> Maintenance: Take 1 tablet orally once daily	#30	

Supportive

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Ampyra® <i>generic equivalent</i>	10mg tablet	Take one tablet orally _____ daily.		

Is patient new to this therapy?  YES  NO | Ship to:  Patient  Office  Other

Prescriber Data

Prescriber Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Contact: \_\_\_\_\_ Preferred Method:  Phone  Fax  Email  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: 844-812-6227 | phone: 855-265-8008 | www.vsprx.com