



Multiple Sclerosis Enrollment Form N-Z

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"/> Plegri [®]	<input type="checkbox"/> Starter Kit Pen	Induction Dosage: Day 1: Inject 63mcg (orange) subcutaneously for 1 dose Day 15: Inject 94mcg (blue) subcutaneously for 1 dose then start maintenance dose on day 29	#1 kit	0 refills
	<input type="checkbox"/> Starter Kit PFS			
<input type="checkbox"/> Rebif [®]	<input type="checkbox"/> 125mcg Pen	Maintenance dose: Inject 125mcg subcutaneously every 14 days	#2	
	<input type="checkbox"/> 125mcg PFS			
	<input type="checkbox"/> PFS Titration Pack	Titration to 22mcg Maintenance Dosage: Week 1: Inject 1/2 syringe (4.4mcg) subcutaneously 3 times per week Week 2: Inject 1/2 syringe (4.4mcg) subcutaneously 3 times per week Week 3: Inject 1/2 syringe (11mcg) subcutaneously 3 times per week Week 4: Inject 1/2 syringe (11mcg) subcutaneously 3 times per week	#1 pack	0 refills
	<input type="checkbox"/> 22mcg PFS	Maintenance dose: Inject 22mcg subcutaneously 3 times weekly	#12	
	<input type="checkbox"/> 22mcg Rebidose Pen			
<input type="checkbox"/> PFS Titration Pack	Titration to 44mcg Maintenance Dosage: Week 1: Inject 1 syringe (8.8mcg) subcutaneously 3 times per week Week 2: Inject 1 syringe (8.8mcg) subcutaneously 3 times per week Week 3: Inject 1 syringe (22mcg) subcutaneously 3 times per week Week 4: Inject 1 syringe (22mcg) subcutaneously 3 times per week	#1 pack	0 refills	
<input type="checkbox"/> 44mcg PFS	Maintenance dose: Inject 44mcg subcutaneously 3 times weekly	#12		
<input type="checkbox"/> 44mcg Rebidose Pen				
<input type="checkbox"/> Tecfidera [®] <i>generic equivalent</i>	<input type="checkbox"/> 120mg capsule	Induction: Take 1 capsule orally twice daily for 7 days	#14	0 refills
	<input type="checkbox"/> 240mg capsule	Maintenance: Take 1 capsule orally twice daily	#60	

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**