Multiple Sclerosis Intake Form

Northborough, MA: **Toll free** (855) 880-1091 **Toll free fax** (844) 265-0265
www.AllCarePlusPharmacy.com

DATE: _____ THERAPY START DATE: _____ DELIVERY : ☐ PATIENT ☐ OFFICE ☐ OTHER: _____

PATIENT INFO

Patient Name | Date of Birth

Address

City, State, Zip

Phone

Social Security ☐ Male ☐ Female

PRESCRIBER INFO

Prescriber Name | DEA/NPI #

Preparer Name/Office Contact | Group/Hospital

Address

City, State, Zip

Phone | Fax

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

ICD-10 Code: _____ ☐ Relapsing/Remittting ☐ Progressive

Has the patient received injection training? ☐ Yes ☐ No

Is the patient interested in patient support programs? ☐ Yes ☐ No

Height: _____ Weight: _____

ALLERGIES: _____

PRESCRIPTION INFORMATION

DRUG	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Aubagio®**	☐ 7 mg ☐ 14 mg	☐ Take one tablet by mouth once daily	☐ 28-day supply (1 box) ☐ 84-day supply (3 boxes) ☐ _____	
☐ **Avonex®**	☐ 30 mcg Prefilled Syringe ☐ 30 mcg Single Dose Vial ☐ 30 mcg Avonex Pen (single dose)	☐ Inject 30 mcg intramuscularly once a week	☐ 4-week supply (1 kit) ☐ 12-week supply (3 kits)	
☐ **Betaseron®**	☐ 0.3 mg	☐ Inject 0.25 mg (1 ml) subcutaneously every other day ☐ Dose Titration: • Week 1-2: Inject 0.0625mg / 0.25 ml subcutaneously QOD • Week 3-4: Inject 0.125 mg / 0.50 ml subcutaneously QOD • Week 5-6: Inject 0.1875 mg / 0.75 ml subcutaneously QOD • Week 7+: Inject 0.25 mg / 1 ml subcutaneously QOD ☐ Other: _____	☐ 28-day supply (1 kit of 14 vials) ☐ 84-day supply (3 kits of 14 vials) ☐ _____	
☐ **BETAJECT® Lite Auto injector**		Use as directed		
☐ **Copaxone®**	☐ 20 mg Prefilled Syringe ☐ 40 mg Prefilled Syringe	☐ Inject 20 mg subcutaneously daily ☐ Inject 40 mg subcutaneously 3 times weekly	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits)	
☐ **Autoject® for glass syringe injection device**		Use as directed		
☐ **Extavia®**	☐ 0.3 mg	☐ Inject 0.25 mg (1 ml) subcutaneously every other day ☐ Dose Titration: • Week 1-2: Inject 0.0625mg / 0.25 ml subcutaneously QOD • Week 3-4: Inject 0.125 mg / 0.50 ml subcutaneously QOD • Week 5-6: Inject 0.1875 mg / 0.75 ml subcutaneously QOD • Week 7+: Inject 0.25 mg / 1 ml subcutaneously QOD ☐ Other: _____	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits)	
☐ **EXTAVIA® Auto-Injector II**		Use as directed		
☐ **Gilenya®**	☐ 0.5 mg	☐ Take one 0.5 mg capsule by mouth daily	☐ 30 day supply (bottle)	
☐ **Ocrevus™**	☐ 300 mg/10 mL (30 mg/mL) single dose vial	☐ Induction Dose: Infuse 300 mg IV, followed two weeks later by a second 300 mg IV infusion. ☐ Maintenance Dose: Infuse 600 mg IV every 6 months	☐ 2 Vials ☐ _____	
☐ **Plegridy®**	☐ 63 mcg/94 mcg PEN Starter Pack ☐ 125 mcg PEN Maintenance Pack ☐ 63 mcg/94 mcg Prefilled Syringe Starter Park ☐ 125 mcg Prefilled Syringe Maintenance Pack	☐ Dose Titration: Day 1 inject 63 mcg, Day 15 inject 94 mcg Day 29 inject 125 mcg ☐ Maintenance dose: 125 mcg subcutaneously every 14 days ☐ Other: _____	☐ 1 kit ☐ 3 kits	
☐ **Rebif®**	☐ Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) ☐ 22 mcg prefilled syringe ☐ 44 mcg prefilled syringe ☐ Titration Pack Rebidose® (six 8.8 mcg pre-filled auto injectors & six 22 pre-filled auto injectors) ☐ Rebidose® 22 mcg pre-filled auto injector ☐ Rebidose® 44 mcg pre-filled auto injector	☐ Dose Titration: • Weeks 1-2: Inject 8.8 mcg subcutaneously three times a week • Weeks 3-4: Inject 22 mcg subcutaneously three times a week • Weeks 5+: Inject 44 mcg subcutaneously three times a week ☐ Inject 44 mcg subcutaneously three times a week ☐ Other: _____	☐ 4-week supply (1 kit) ☐ 12-week supply (3 kits) ☐ _____	
☐ **Rebiject®**		Use as directed		
☐ **Tecfidera™**	☐ Titration Starter Pack (14 capsules of 120 mg and 46 capsules of 240 mg) ☐ 240 mg capsules ☐ 120 mg capsules	☐ Titration Starter Pack: Take 120 mg capsule by mouth twice a day for 7 days followed by 240 mg capsule by mouth twice a day ☐ Maintenance dose: Take 240 mg capsule by mouth twice a day ☐ Other: _____	☐ Titration Starter Pack: 30 day supply ☐ Maintenance Dose (240 mg) ☐ 30 day supply ☐ 90 day supply ☐ Other_____ ☐ 120 mg capsules: ☐ 7 day supply ☐ Other_____	
☐ **Zinbryta™**	☐ 150 mg/mL solution in a single-dose prefilled syringe	☐ 150 milligrams injected subcutaneously once monthly		
☐ **Tysabri®**	**Please complete a MS TOUCH/Tysabri enrollment form and indicate AllCare Plus Pharmacy as your preferred pharmacy provider. Please contact TOUCH Prescribing Program with any questions. 1-800-456-2255**			

Other Medication: _____

Physician Signature: _____ Date: _____

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.