



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		PRESCRIBER INFO	
Patient Name	Date of Birth	Prescriber Name	DEA/NPI #
Address		Preparer Name/Office Contact	Group/Hospital
City, State, Zip		Address	
Phone		City, State, Zip	
Social Security		Phone	Fax
<input type="checkbox"/> Male <input type="checkbox"/> Female			

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

CLINICAL INFORMATION

ICD-10 Code: _____ Relapsing/Remitting Progressive

Height: _____ Weight: _____

Has the patient received injection training? Yes No

Is the patient interested in patient support programs? Yes No

ALLERGIES: _____

PRESCRIPTION INFORMATION

DRUG	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Aubagio®	<input type="checkbox"/> 7 mg <input type="checkbox"/> 14 mg	<input type="checkbox"/> Take one tablet by mouth once daily	<input type="checkbox"/> 28-day supply (1 box) <input type="checkbox"/> 84-day supply (3 boxes)	
<input type="checkbox"/> Avonex®	<input type="checkbox"/> 30 mcg Prefilled Syringe <input type="checkbox"/> 30 mcg Single Dose Vial <input type="checkbox"/> 30 mcg Avonex Pen (single dose)	<input type="checkbox"/> Inject 30 mcg intramuscularly once a week	<input type="checkbox"/> 4-week supply (1 kit) <input type="checkbox"/> 12-week supply (3 kits)	
<input type="checkbox"/> Betaseron®	<input type="checkbox"/> 0.3 mg	<input type="checkbox"/> Inject 0.25 mg (1 ml) subcutaneously every other day <input type="checkbox"/> 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 <input type="checkbox"/> Other: _____	<input type="checkbox"/> 28-day supply (1 kit of 14 vials) <input type="checkbox"/> 84-day supply (3 kits of 14 vials)	
<input type="checkbox"/> BETAJECT® Lite Auto injector		Use as directed		
<input type="checkbox"/> Copaxone®	<input type="checkbox"/> 20 mg Prefilled Syringe <input type="checkbox"/> 40 mg Prefilled Syringe	<input type="checkbox"/> Inject 20 mg subcutaneously daily <input type="checkbox"/> Inject 40 mg subcutaneously 3 times weekly	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits)	
<input type="checkbox"/> Autoject® for glass syringe injection device		Use as directed		
<input type="checkbox"/> Extavia®	<input type="checkbox"/> 0.3 mg	<input type="checkbox"/> Inject 0.25 mg (1 ml) subcutaneously every other day <input type="checkbox"/> 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 <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits)	
<input type="checkbox"/> EXTAVIA® Auto-Injector II		Use as directed		
<input type="checkbox"/> Gilenya®	<input type="checkbox"/> 0.5 mg	<input type="checkbox"/> Take one 0.5 mg capsule by mouth daily	<input type="checkbox"/> 30 day supply (bottle)	
<input type="checkbox"/> Ocrevus™	<input type="checkbox"/> 300 mg/10 mL (30 mg/mL) single dose vial	<input type="checkbox"/> Induction Dose: Infuse 300 mg IV, followed two weeks later by a second 300 mg IV infusion. <input type="checkbox"/> Maintenance Dose: Infuse 600 mg IV every 6 months	<input type="checkbox"/> 2 Vials	
<input type="checkbox"/> Plegridy®	<input type="checkbox"/> 63 mcg/94 mcg PEN Starter Pack <input type="checkbox"/> 125 mcg PEN Maintenance Pack <input type="checkbox"/> 63 mcg/94 mcg Prefilled Syringe Starter Pack <input type="checkbox"/> 125 mcg Prefilled Syringe Maintenance Pack	<input type="checkbox"/> Dose Titration: Day 1 inject 63 mcg, Day 15 inject 94 mcg Day 29 inject 125 mcg <input type="checkbox"/> Maintenance dose: 125 mcg subcutaneously every 14 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 kit <input type="checkbox"/> 3 kits	
<input type="checkbox"/> Rebif®	<input type="checkbox"/> Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) <input type="checkbox"/> 22 mcg prefilled syringe <input type="checkbox"/> 44 mcg prefilled syringe <input type="checkbox"/> Titration Pack Rebidose® (six 8.8 mcg pre-filled auto injectors & six 22 pre-filled auto injectors) <input type="checkbox"/> Rebidose® 22 mcg pre-filled auto injector <input type="checkbox"/> Rebidose® 44 mcg pre-filled auto injector	<input type="checkbox"/> 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 <input type="checkbox"/> Inject 44 mcg subcutaneously three times a week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4-week supply (1 kit) <input type="checkbox"/> 12-week supply (3 kits)	
<input type="checkbox"/> Rebitect®		Use as directed		
<input type="checkbox"/> Tecfidera™	<input type="checkbox"/> Titration Starter Pack (14 capsules of 120 mg and 46 capsules of 240 mg) <input type="checkbox"/> 240 mg capsules <input type="checkbox"/> 120 mg capsules	<input type="checkbox"/> 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 <input type="checkbox"/> Maintenance dose: Take 240 mg capsule by mouth twice a day <input type="checkbox"/> Other: _____	<input type="checkbox"/> Titration Starter Pack: 30 day supply <input type="checkbox"/> Maintenance Dose (240 mg) <input type="checkbox"/> 30 day supply <input type="checkbox"/> 90 day supply <input type="checkbox"/> Other <input type="checkbox"/> 120 mg capsules: <input type="checkbox"/> 7 day supply <input type="checkbox"/> Other	
<input type="checkbox"/> Zinbryta™	<input type="checkbox"/> 150 mg/mL solution in a single-dose prefilled syringe	<input type="checkbox"/> 150 milligrams injected subcutaneously once monthly		
<input type="checkbox"/> 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.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265