Multiple Sclerosis Pharmacy Intake Form



1-718-762-7400 Phone: *1-718-762-7404* Toll Free: 1-888-93-EVERS

Address: City: State: Zip Code: Phone # (Daytime): Phone # (Daytime): Phone # (Daytime): Phone # (Evening): Phone # (Eveni	Provider Representative	Phone	Date Needed	Ship to	□Specialty Care Center	□Patient's	Home
Patient Name:				□Prescriber	r's Office □Other		
Address: City: State: Zip Code:	PATIENT INFORM	MATION					
Address: City: State: Zip Code:	Patient Name:		DOB:_		Male Fen	nale	
CLINICAL ASSESSMENT Patient is New to Therapy Patient is Currently on Therapy Start Diagnosis: RRMS SPMS PPMS PRMS Diagnosis: RRMS Self Starting Startin					- <u> </u>		
Phone # (Daytime):				Zip Code:			
E-mail Address: Insurance Provider (Please include copy of front and back of card): D# Phone #: Phone #:	-			-			
Name of Insured: Relationship to Patient: Self Other: Prescription Card: Self Other: Patient is New to Therapy Restart Patient is Currently on Therapy (Start Date: Slagnosis: RNMS SPMS SPMS SPMS SPMS SPMS SPMS SPMS S	-			_			
Relationship to Patient: Self Other: Policy/Group #: Patient is Eligible for Medicare Policy/Group #: Poli							
Relationship to Patient: Self Other: Policy/Group #: Prescription Card: Yes No Carrier: Policy/Group #: Policy			-				
Prescription Card:							
Patient is New to Therapy Restart Patient is Currently on Therapy Gtart Date: Prefiled Syringes Lyo Vial Betaseron* (interferon beta-la) 30 mcg Betaseron* (interferon beta-lb) Copaxone* (glatiramar acetate) 20 mg Prefiled Syringes Lyo Vial Prefiled Syringes Current Weight: Date: Copaxone* (glatiramar acetate) 20 mg Prefiled Syringes Current Weight: Date: Copaxone* (glatiramar acetate) 20 mg Prefiled Syringes Current Weight: Copaxone* Extavia* (interferon beta-lb) Cilenya* (fingolimod) 0.5 mg capsules Copaxone* Extavia* (interferon beta-la) Titration Kit Capaxone*							
Patient is New to Therapy Restart Patient is Currently on Therapy Glart Date: Prefiled Syringes Lyo Vial Lyo Management Medications Lyo Management Medicatio	Prescription Card: Yes	, No Carri	ier:		Policy/Group #:		
Restart Patient is Currently on Therapy (Start Date:	CLINICAL ASSESS	SMENT	Medica	tion	Dose/Directions/	/Freq Q	ty Refills
Prefilled Syringes Lyo Vial Betaseron* (interferon beta-lb)		herapy		n beta-la)			
Betaseron® (interferon beta-lb)		ani	☐ 30 mcg ☐ Prefilled Syringes	☐ Lyo Vial			
Copaxone* (glatiramar acetate)					٥)		
Diagnosis: RRMS SPMS PPMS PRMS Date of Diagnosis: Current Weight: Date: Date:					+		
Date of Diagnosis: Current Weight: Date: Gilenya* (fingolimod) Dote Dote				_			
Current Weight: Date:			□ Extavia® (interfer				
Copaxone* Extavia* Gilenya* Other Therapies Tried & Failed (Please List): 10 mg/5 mL 20 mg/10 mL Other 20 mg/10 mL Other 20 mg/10 mL Other 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL 20 mg/10 mL			☐ 0.5 mg capsules				
Other Therapies Tried & Failed (Please List): Rebif* (Interferon beta-la)	□ Copaxone® □ Extavia® □ Gilenya®		☐ 10 mg/5 mL				
Tysabri® - Contact Touch (Biogen Idec) at 1-800-456-2255 or at 1-800-840-1278 (fax) Other			☐ Titration Kit☐ 22 mcg Prefilled Sy	Syringes			
Other Health Conditions: Allergies: Ampyra® (dalfampridine) Double Extended Release Tablet Lioresal® IT (baclofen) Other: PRESCRIBER INFORMATION Prescriber's Name: Address: City: State: Fax: Best Time to Call: State License #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.				_	 Idec) at 1-800-456-2255	or at 1-800-8	40-1278 (fax)
Allergies: Ampyra® (dalfampridine) Doncomitant Medications: Concomitant Medications: Diamage Extended Release Tablet Concomitant Medications: Diamage Extended Release Tablet Cother: Other: Practice/Facility Name: Office Contact: City: State: Zip Code: Phone #: State License #: DEA #: NPI#: Medicaid UPIN #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: It certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.	Other Health Conditions:					<u> </u>	10 12.
Allergies: Ampyra® (dalfampridine)					Management Medicati	ons	
	Allergies:		Amnyra® (dalfamp	, -	Management	9116	
Prescriber's Name: Practice/Facility Name: Office Contact: City: State: Zip Code: Best Time to Call: State License #: DEA #: NPI#: Medicaid UPIN #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: It certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.			☐ 10 mg Extended Re	Release Tablet			
Prescriber's Name: Practice/Facility Name: Office Contact: Office Contact: Office Contact: Phone #: Fax: Best Time to Call: State License #: DEA #: NPI#: Medicaid UPIN #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.	Concomitant Medications:		☐ Lioresal® IT (bac	clofen)			
Prescriber's Name: Practice/Facility Name: Office Contact: Office Contact: Office Contact: Phone #: Fax: Best Time to Call: State License #: DEA #: NPI#: Medicaid UPIN #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.			☐ Other:				
Prescriber's Name: Practice/Facility Name: Office Contact: Office Contact: Office Contact: Office Contact: Office Contact:	PRESCRIBER INF	ORMATION					
Address:Office Contact:			Practice	/Facility Name	0.		
City: State: Zip Code: Phone #: Fax: Best Time to Call: State License #: DEA #: NPI#: Medicaid UPIN #: In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.							
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Necessary," or your state specific required language to prohibit substitution: I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.							
	Necessary," or your state sp	pecific required langua	age to prohibit substit	itution:	,		,
···							age.

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