Bell Pharmacy

Multiple Sclerosis Enrollment Form

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PATIENT INFORMATION

Name:		Date of Birth:		O Male O Female	
Address:		City:	State:	Zip:	
Phone:		Alt Phone:		Email:	
SS #:		Primary Language:		Emergency Contact:	

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:	
Supervising Physician:				NPI#:	
Address:	City:	State:	Zip:	Tax ID:	
Phone:	Fax:			Office Contact:	

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

O G35 Multiple Sclerosis O Other ICD10 _____ Is patient new to therapy: O Yes O No

Date of Diagnosis: _____ Date of first demyelinating event: _____

Type:	O Relapsing-Remitting	O Secondary progressive with relapses	O Primary Progressive
	O Secondary progressive without relapses	O Clinically Isolated Syndrome (CIS)	O Progressive-relapsing

Drug Allergies: O NKDA

PREVIOUS THERAPIES:	Strength and Dose	Date of Therapy	Reason for discontinuing:
O _____	O _____	_____	_____
O _____	O _____	_____	_____
O _____	O _____	_____	_____

PRESCRIPTION INFORMATION

Needs by Date: Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other

Drug	Dose	Direction	Quantity	Refills
O Avonex	O 30 mcg Pre-filled Syringe O 30 mcg Single Dose Vial O 30 Avonex Pen (single Dose)	O Inject 30 mcg intramuscularly once a week	O 4 week supply - 1 kit O 12 week supply - 3 kits	
O Betaseron	O 0.3 mg	O Inject 0.25 mg (1ml) subcutaneously every other day O Dose Titration: Weeks 1-2: 0.0625 mg (0.25ml) subcutaneously every other day Weeks 3-4: 0.125 mg (0.50ml) subcutaneously every other day Weeks 5-6: 0.1875 mg (0.75ml) subcutaneously every other day Weeks 7+: 0.25 mg (1ml) subcutaneously every other day O Other: _____	O 28 day supply 1 kit of 14 vials O 84 day supply 3 kits of 14 vials O Other: _____	
	O BETAJECT Lite Autoinjector	O Use as directed	O _____	
O Copaxone	O 20 mg Pre-filled Syringe	O Inject 20 mg subcutaneously daily	O 30 day supply O 90 day supply	
	O Autoject 2			
O Gilenya	O 0.5 mg	O Take one capsule by mouth once daily O Other: _____	O 1 Box - 28 capsules	
O Rebif O Rebif Redidose	O 8.8 mcg (0.2ml) O 22 mcg (0.5ml) O 44 mcg (0.5ml)	O 8.8 mcg (0.2ml) subcutaneously three times weekly for weeks 1-2, THEN 22mcg (0.5ml) subcutaneously three times weekly for weeks 3-4 O 22 mcg (0.5ml) subcutaneously three times weekly O 44 mcg (0.5ml) subcutaneously three times weekly	O 4 week supply	
O Extavia	O 0.3 mg	O Inject 0.25mg (1ml) subcutaneously every other day O Dose Titraion: Weeks 1-2: 0.0625mg (0.25ml) subcutaneously every other day Weeks 3-4: 0.125mg (0.50ml) subcutaneously every other day Weeks 5-6: 0.1875mg (0.75ml) subcutaneously every other day Weeks 7+: 0.25 mg (1ml) subcutaneously every other day O Other: _____	O 30 day supply - 1 kit O 90 day supply - 3 kits	
	O EXTAVIA Auto Injector II	O Use as directed	O _____	

INJECTION TRAINING

O Patient has received pen and injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.