



Multiple Sclerosis Enrollment Form

Phone: 1-866-516-4121 Fax: 314-652-4126

Last Name	First Name	Sex	Date of Birth	Today's Date	Date Needed
Home Address		City	State	Zip	Physician's Name (please print)
Shipping Address (if different from home address)				Address	City State Zip
Home Phone Number ()		Alternate Phone Number ()		DEA #	
Member ID					
Delivery Instructions: Home <input type="checkbox"/> Work <input type="checkbox"/> Physician <input type="checkbox"/> Other <input type="checkbox"/> _____					
Primary Insurance Company			Phone	Name of Insured/SSN	Employer Name/ID Number Group Number
Secondary/Supplemental Insurance Company			Phone	Name of Insured/SSN	Employer Name/ID Number Group Number
Primary Diagnosis: <input type="checkbox"/> RRMS <input type="checkbox"/> SPMS <input type="checkbox"/> PPMS Date of Diagnosis: _____ ICD 9 Code: _____ Estimated Start of Therapy: _____					
Patient Training: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Nursing Visit <input type="checkbox"/> Other: _____					
Allergies:				Special Instructions: (non-english speaking patients, etc.)	

<p>Copaxone 20 mg Prefilled Syringe Quantity: _____ Refill x _____</p> <p>Directions: <input type="checkbox"/> Inject 20 mg prefilled syringe SC QD <input type="checkbox"/> Other: _____</p>	<p>Avonex 30 mcg <input type="checkbox"/> Vial <input type="checkbox"/> PFS Quantity: _____ Refill x _____</p> <p>Directions: <input type="checkbox"/> Inject 30 mcg IM once weekly <input type="checkbox"/> Other: _____</p>
<p><input type="checkbox"/> Rebif Titration Pack #12 Refill x 0 <input type="checkbox"/> Inject 8.8 mcg (0.2 ml) SC TIW x2 weeks, 22 mcg (0.5 ml) TIW x 2 weeks</p> <p>Rebif <input type="checkbox"/> 22 mcg Prefilled Syringe Quantity: _____ Refill x _____ <input type="checkbox"/> Inject 8.8 mcg (0.2 ml) SC TIW x 2 weeks, 22 mcg (0.5ml) SC TIW x 2 weeks <input type="checkbox"/> Inject 22 mcg (0.5 ml) SC TIW x 4 weeks <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> 44 mcg Prefilled Syring Quantity: _____ Refill x _____ <input type="checkbox"/> Inject 44 mcg (0.5 ml) SC 3 x per week</p> <p><input type="checkbox"/> Rebifect II Device</p>	<p>Betaseron 0.25mg Quantity: _____ Refill x _____</p> <p>Directions: <input type="checkbox"/> Mix with 1.2 mL of provided diluent and inject 0.25 mg (1mL) SC QOD <input type="checkbox"/> Dose titration: Mix with 1.2mL or provided diluent and: Inject 0.25mL (0.0625 mg) SC QOD for weeks 1-2 Inject 0.50mL (0.125 mg) SC QOD for weeks 3-4 Inject 0.75mL (0.1875 mg) SC QOD for weeks 5-6 Inject 1mL (0.25 mg) SC QOD thereafter <input type="checkbox"/> Other: _____</p>

PHYSICIAN SIGNATURE REQUIRED

Physician Signature: _____ Dispense as Written Generic Substitution Permissible