Multiple Sclerosis Enrollment and Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

PATIENT INFORMATION

Patient Name _____
DOB ___/___/_____ SSN _____ Gender_____
Weight _____ Height _____ Phone _____
Address _____
City, State, Zip _____
Cell Phone _____ E-Mail _____

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name _____
Insurance Co. Phone _____ Group# _____
Policy Holder Name _____
Policy Holder Employer _____
Relationship to Patient _____
ID# _____ RxBIN _____ PCN_____

PRESCRIBER INFORMATION

Prescriber's Name _____
Practice Name _____
DEA _____ NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Office Contact Person _____
Office Contact EMAIL _____
Prescription Date _____ Date Needed _____

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber Signature _____

Ship to: ☐Patient ☐Prescriber's Office ☐Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis _____ ICD-10 Code _____
Type: ☐ Relapse Remitting ☐ Primary Progressive ☐ Secondary Progressive ☐Progressive Relapsing
☐ Other (please explain)_____
Date Diagnosed: _____ No. of Relapses in the Past Yr & Dates: _____
Most Recent MRI Date: _____ Any changes on MRI? ☐ YES☐ NO *Explain* _____
Drug Allergies _____ Latex Allergy ☐ YES ☐NO
Other Disease States or Comorbities _____
List Prior Treatment and Dates: _____
What was response to Treatment? _____
Relevant Lab Values (WBC, Platelets, B12 Levels, TSH) _____
Additional Comments _____

PRESCRIPTION INFORMATION *(please indicate days supply if different than 30 days)*

☐ **Avonex® (interferon - β1a)** ☐ 30mcg Vial ☐ 30mcg Syringe ☐ 30mcg Pen
Directions: _____ 30 Days Supply? ☐YES ☐NO Refills _____

☐ **Betaseron® (interferon - β1b)** ☐ 0.3mg Vial
Directions: _____ 30 Days Supply? ☐YES ☐NO Refills _____

☐ **Copaxone® (glatiramer acetate)** ☐ 20mg Syringe ☐ 40mg Syringe
Directions: _____ 30 Days Supply? ☐YES ☐NO Refills _____

☐ **Extavia® (interferon - β1b)** ☐ 0.3mg Vial
Directions: _____ 30 Days Supply? ☐YES ☐NO Refills _____

☐ **Gilenya® (fingolimod)** 0.5mg Capsules
Directions: _____ 30 Days Supply? ☐YES ☐NO Refills _____

☐ **Plegridy® (peginterferon beta-1a)**
☐ PEN STARTER Pack: Inject 63mcg SQ day 1 and 94mcg SQ day 15 Quantity 2
☐ SYRINGE STARTER Pack: Inject 63mcg SQ day 1 and 94mcg SQ day 15 Quantity 2
☐ PEN MAINTENANCE Pack: Inject 125 mcg SQ every 14 days Quantity 2 Refills _____
☐ SYRINGE MAINTENANCE Pack: Inject 125 mcg SQ every 14 days Quantity 2 Refills _____

☐ **Rebif® (interferon - β1a)** ☐ Syringe ☐Rebidose Auto-Injector Dose: ☐Titration Pack ☐ 22mcg ☐ 44mcg
Directions: _____ 30 Days Supply? ☐YES ☐NO Refills _____

☐ **Tecfidera® (dimethyl fumarate)**
☐ STARTER PACK: 120mg twice daily for 7 days then 240mg twice daily for 23 days with or without food Quantity 60
☐ MAINTENANCE Dose: 240mg orally twice a day with or without food Quantity 60 Refills _____
☐ OTHER Dosing: _____ Quantity _____ Refills _____