



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: _____
 Drug Allergies _____ Latex Allergy YES NO
 Other Disease States or Comorbidities _____
 List Prior Treatment and Dates: _____
 What was response to Treatment? _____
 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 _____

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

Dalfampridine ER 10mg Tablet
 Directions: Take one tablet by mouth twice daily 30 Days Supply? YES NO Refills _____

Gilenya® (fingolimod) 0.5mg Capsules
 Directions: Take 1 capsule by mouth once daily 30 Days Supply? YES NO Refills _____

Kesimpta® (ofatumumab) 20mg injection
 Loading Dose: 1 SQ injection at week 0, 1, and 2
 Maintenance Dose: 1 SQ injection monthly 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 _____

Vumerity™ (diroximel fumarate)
 STARTER PACK: 231mg twice daily for 7 days then 462mg twice daily for 23 days with food Quantity 106
 MAINTENANCE Dose: 462mg orally twice a day with food Quantity 120 Refills _____

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.