Multiple Sclerosis Enrollment Form (A-F)

PYRAMIDS SPECIALTY PHARMACY

www.pyramidspharmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: ❑Male ❑Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):
❑ G35 Multiple Sclerosis (MS)
❑ Other: _____

MS Subtype:
❑ Relapsing-remitting
❑ Secondary Progressive
Does the patient have documented relapses? ❑ Yes ❑ No
❑ Primary Progressive
❑ Clinically isolated syndrome

Number of relapses in past year: _____

Date of last MRI: _____
MRI changes: ❑ Yes ❑ No

Has pregnancy been excluded?
❑ Yes ❑ No
Date of test: _____

For Mitoxantrone patients:
LVEF <50%? ❑ Yes ❑ No
Lifetime dose (mg/m^2): _____
(Not to exceed cumulative dose >140 mg/m2)

Please list previously tried/failed therapies and reason for discontinuation:

_____

_____

_____

_____

_____

_____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
☐ Avonex®	☐ 30 mcg Vial (SUV) ☐ 30 mcg Prefilled Syringe ☐ 30 mcg Autoinjector	☐ Inject 30 mcg intramuscularly once a week. ☐ Other: _____		
☐ Betaseron®	☐ 0.3 mg Vial Kit	☐ **Initial Titration Dose**: Weeks 1-2: Inject 0.0625 mg (0.25 mL) subQ every other day. Weeks 3-4: Inject 0.125 mg (0.5 mL) subQ every other day. Weeks 5-6: Inject 0.1875 mg (0.75 mL) subQ every other day. Weeks 7+: Inject 0.25 mg (1 mL) subQ every other day. ☐ **Maintenance Dose**: Inject 0.25 mg (1 mL) subQ every other day.		
☐ Copaxone®	☐ 20 mg Prefilled Syringe	☐ Inject 20 mg subQ once daily.		
	☐ 40 mg Prefilled Syringe **(Note: Products are not interchangeable.)**	☐ Inject 40 mg subQ three times a week, at least 48 hours apart.		
☐ Dalfampridine	☐ 10 mg Extended Release Tablet	☐ Take one tablet (10 mg) by mouth every 12 hours.		
☐ Extavia®	☐ 0.3 mg Vial Kit	☐ **Initial Titration Dose**: Weeks 1-2: Inject 0.0625 mg (0.25 mL) subQ every other day. Weeks 3-4: Inject 0.125 mg (0.5 mL) subQ every other day. Weeks 5-6: Inject 0.1875 mg (0.75 mL) subQ every other day. Weeks 7+: Inject 0.25 mg (1 mL) subQ every other day. ☐ **Maintenance Dose**: Inject 0.25 mg (1 mL) subQ every other day.		

Deliver to: ❑Patient ❑Office ❑Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

❑Product Substitution Permitted ❑Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____