MULTIPLE SCLEROSIS ENROLLMENT FORM

Kings Pharmacy 33 Park Avenue Newark, NJ 07104 Phone: 888-644-8633 Fax: 800-922-5150

DATE ________________ NEEDS BY DATE ________________ SHIP TO ◯ Patient ◯ Office

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name ______________________ Date of Birth ____ /_____ /____ Sex: ◯ Male ◯ Female
Address ______________________ City ____________ State _______ Zip ____________
Home Phone ________________ Alternate Phone ________________ Social Security # ________________

PRESCRIBER INFORMATION

Prescriber's Name ______________________ DEA # ______________ NPI# ______________
Address ______________________ City ____________ State _______ Zip ____________
Phone ________________ Fax ________________

INSURANCE INFORMATION

(Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card Name of Insurer ________________ ID# ________ BIN ________ PCN ________ Group ______
Primary Insurance Subscriber ________________ ID# ________
Is the Patient eligible for Medicare? ◯ Yes ◯ No

STATEMENT OF MEDICAL NECESSITY

(Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization)

Diagnosis Description ________________ Diagnosis: (ICD-9 code) __________ Date of Diagnosis _________

OTHER CLINICAL INFORMATION/COMMENTS

Weight ________ ◯ Kg ◯ Lbs Height ________ ◯ inches ◯ cm BSA ________________ m^2
Other Conditions ______________________________
Other Medications ______________________________
Allergies ______________________________ ◯ No Known Drug Allergy
Previous Therapies ______________________________

TEST RESULTS		WNL			WNL
Serum Creatine	____________	◯ Yes ◯ No	Magnesium	____________	◯ Yes ◯ No
Liver Function	____________	◯ Yes ◯ No	ECG	____________	◯ Yes ◯ No
Potassium	____________	◯ Yes ◯ No	baseline BP	____________	◯ Yes ◯ No

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG.	QTY.	REF.
◯ Avonex(R)	☐30mcg ☐PFS ☐Vials	Inject 30mcg IM weekly	1 Kit (4 Doses)	
◯ Copaxone(R)	☐20mg/mL PFS	Inject 20mg SQ every day	1 Kit (30 Doses)	
◯ Gilenya(R)	☐0.5mg Capsule	Take 1 capsule PO daily	28 caps	
◯ Betaseron(R)	☐0.25 mg (1 ml) SQ every other day	☐ (Titration) SQ: **Wk1&2:** 0.0625 mg (0.25ml) QOD **Wk3&4:** 0.125 mg (0.5ml) QOD **Wk7+:** 0.25 mg (1ml) QOD	1 kit (14 doses)	
◯ Extavia(R) ◯ Rebif(R)	☐44mcg ☐ 22mcg PFS SQ TIW	☐ Titration Kit: **Wk1&2:** Inject 8.8 mcg SQ TIW **Wk3&4:** Inject 22 mcg SQ TIW **Wk5+:** Inject 44 mcg SQ TIW	1 kit (12 doses)	
◯ Novantrone	☐2mg/mL Solution	Infuse ____ mg (12mg/m^2) IV Q 3 months MAX: 140 mg/m^2 cumulative dose	1 dose	
◯ Botox 100 Unit				

◯ Please enroll my patient into the following manufacturer support program: ______________________

I hereby freely and voluntarily have selected Kings Pharmacy to dispense the medication herin prescribed by my physician.
Patient Signature: ______________________

PHYSICIAN'S SIGNATURE

______________________________ ______________________________
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

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