Multiple Sclerosis Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: customerservicefax@caremark.com

Coram® CVS specialty infusion services

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: Abington Neurological Associates

Address: 1151 Old York Road, Suite 200 City, State, ZIP: Abington, PA 19001

Phone: 215-957-9250 Fax 215-957-9254 Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Coram® Ambulatory Infusion Suite ☐ Other: _____

☐ Infusion Site: Name: _____ Address: _____

(Please include street address, suite #, city, state, ZIP)

Diagnosis (ICD-10):

☐ G35 Multiple Sclerosis (MS) ☐ Other Code: _____ Description _____

For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

If MS, please indicate type:
☐ Primary progressive MS (PPMS) ☐ Relapsing-remitting MS (RRMS) ☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No

Height: _____in/cm Weight: _____lb/kg Allergies: _____

Has pregnancy been excluded? ☐ Yes ☐ No ☐ Not applicable (e.g., male, post-menopause)

For Gilenya: Please provide the patient's QTc interval: _____ms ☐Unknown

Is the patient currently receiving therapy with Gilenya? ☐ Yes ☐ No

MS drug(s) not able to use:

Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____

Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____

Nursing:

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary ☐ Yes ☐ No

Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

Injection training not necessary. Date training occurred: _____

Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

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Medications A-D
Multiple Sclerosis Enrollment Form
(Aubagio®, Avonex®, Bafiertam™, Betaseron®, Copaxone®, Dalfampridine, Dimethyl Fumarate)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aubagio	☐ 7 mg ☐ 14 mg	Take one tablet by mouth once a day.	Quantity: ☐ 30-day supply (1 bottle) ☐ 90-day supply (3 bottles) Refills: _____
☐ Avonex	☐ 30 mcg prefilled syringe ☐ 30 mcg pen (single doses)	Inject 30 mcg intramuscularly once a week	Quantity: ☐ 28-day supply (1 box) ☐ 84-day supply (3 kits) Refills: _____
☐ Bafiertam	95 mg capsule	☐ Take one 95 mg capsule by mouth twice a day for 7 days. Starting on Day 8, take 190 mg (two 95 mg capsules) twice a day by mouth ☐ Other: _____	Quantity: ☐ 30-day supply ☐ 90-day supply ☐ Other: _____ Refills: _____
☐ Betaseron ☐ Betaject® Lite Autoinjector	0.3 mg	☐ Inject 0.25 mg (1mL) SC every other day. ☐ Dose Titration: ● Weeks 1-2: Inject 0.0625 mg/0.25 mL SC QOD; ● Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD; ● Weeks 5-6: Inject 0.1875 mg/0.75 mL SC QOD; ● Weeks 7+: Inject 0.25 mg/1 mL SC QOD ☐ Other _____	Quantity: ☐ 28-day supply (1 kit of 14 vials) ☐ 84-day supply (3 kits of 14 vials) Refills: _____
☐ Copaxone ☐ May Substitute	20 mg prefilled syringe	Inject 20 mg SC daily.	Quantity: ☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits) Refills: _____
☐ Copaxone ☐ May Substitute ☐ Autoject® 2 for glass syringe injection device	40 mg prefilled syringe	Inject 40 mg SC three times a week.	Quantity: ☐ 28-day supply (12 syringes) ☐ 84-day supply (36 syringes) Refills: _____
☐ Dalfampridine	10 mg extended release tablet	Take one tablet (10 mg) twice daily (approximately 12 hours apart)	Quantity: ☐ 30-day supply ☐ 90-day supply Refills: _____
☐ Dimethyl Fumarate	Starter Pack (14 capsules of 120 mg & 46 capsules of 240 mg)	Take one 120 mg capsule by mouth twice a day for 7 days, followed by one 240 mg capsule by mouth twice a day.	Quantity: 30-day supply Refills: _____
☐ Dimethyl Fumarate	120 mg capsule	☐ Administer 120mg twice a day orally for seven days. ☐ Other_____	Quantity: ☐ 7-day supply Refills: _____
☐ Dimethyl Fumarate	240 mg capsule	☐ Administer 240mg twice a day orally after day seven ☐ Other_____	Quantity: ☐ 30-day supply ☐ 90-day supply Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

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

X_____ X_____

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Medications E-L
Multiple Sclerosis Enrollment Form
(Extavia®,Gilenya®, Glatiramer Acetate, Glatopa™, Kesimpta®, Lemtrada®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Extavia ☐ Extavia Auto-Injector II	0.3 mg	☐ Inject 0.25 mg (1 mL) SC every other day. ☐ Dose Titration: ● Weeks 1-2: Inject 0.0625 mg/0.25 mL SC QOD ● Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD ● Weeks 5-6: Inject 0.1875 mg/0.75 mL SC QOD ● Weeks 7+: Inject 0.25 mg/1 mL SC QOD ☐ Other _____	Quantity: ☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits) Refills: _____
☐ Gilenya	0.5mg	Take one capsule by mouth daily	Quantity: ☐ 30-day supply (1 bottle) ☐ 90-day supply (3 bottles) Refills: _____
☐ Glatiramer Acetate	40 mg prefilled syringe	Inject 40 mg SC three times a week	Quantity: ☐ 28-day supply (12 syringes) ☐ 84-day supply (36 syringes) Refills: _____
☐ WhisperJECT Autoinjector device (1st fill only)	N/A	Use as directed	Quantity:1 Refills: 0
☐ Welcome Kit (1st fill only)	N/A	Use as directed	Quantity:1 Refills: 0
☐ Glatopa	20 mg prefilled syringe	Inject 20 mg SC daily	Quantity: ☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits) Refills:_____
☐ Kesimpta	☐ 20 mg/0.4 mL single-dose prefilled Sensoready pen ☐ 20 mg/0.4 mL single-dose prefilled syringe	Loading Dose: ☐ Administer 20 mg subcutaneously at Week 0, 1, and 2 Maintenance Dose: ☐ Administer 20 mg subcutaneously once a month starting Week 4	Quantity: ☐ 21-day supply ☐ 30-day supply ☐ 90-day supply Refills:_____ Other:_____
☐ Lemtrada	N/A	Please complete an MS One to One®/Lemtrada enrollment form and indicate CVS Specialty® as your preferred pharmacy provider. (For questions, please contact MS One to One at 1-855-676-6326).	Quantity: 0 Refills: 0

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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Medications M
Multiple Sclerosis Enrollment Form
(Mavenclad®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Mavenclad®	10 mg tablet	Please see below for Week 1 and Week 5 dosing chart Patient Weight: ___kg or ____lb Treatment Course: ☐ Year 1 ☐ Year 2	Week 1: 4-pack; Quantity: ___ 5-pack: Quantity:____ 6-pack; Quantity:____ 7-pack; Quantity_____ 8-pack; Quantity_____ 9-pack; Quantity_____ 10-pack; Quantity_____ Week 5: 4-pack; Quantity: ___ 5-pack: Quantity:____ 6-pack; Quantity:____ 7-pack; Quantity_____ 8-pack; Quantity_____ 9-pack; Quantity_____ 10-pack; Quantity_____ Refills: 0

Number of MAVENCLAD (cladribine) 10 mg tablets per week

Weight Range	Dose in mg (Number of 10 mg Tablets) per Cycle	
kg	First Cycle	Second Cycle
☐ 40 to less than 50	40 mg (4 tablets)	40 mg (4 tablets)
☐ 50 to less than 60	50 mg (5 tablets)	50 mg (5 tablets)
☐ 60 to less than 70	60 mg (6 tablets)	60 mg (6 tablets)
☐ 70 to less than 80	70 mg (7 tablets)	70 mg (7 tablets)
☐ 80 to less than 90	80 mg (8 tablets)	70 mg (7 tablets)
☐ 90 to less than 100	90 mg (9 tablets)	80 mg (8 tablets)
☐ 100 to less than 110	100 mg (10 tablets)	90 mg (9 tablets)
☐ 110 and above	100 mg (10 tablets)	100 mg (10 tablets)

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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X_____ X_____

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Medications M-R
Multiple Sclerosis Enrollment Form
(Mayzent®, Ocrevus™,Plegridy®, Rebif®, Ribiject II®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Mayzent	N/A	Please fax **MAYZENT®** (siponimod) **Prescription Start Form to** Mayzent's HUB Alongside MS, at 1-877-750-9068	Quantity: 0 Refill: 0
☐ Ocrevus	300 mg/10 mL (30 mg/mL) single dose vial	☐ Induction: Infuse 300 mg IV over approximately 2.5 hours. Follow with a second 300 mg IV infusion over approximately 2.5 hours two weeks later. Infusions may be interrupted or slowed as needed. ☐ Maintenance: Infuse 600 mg IV over approximately 3.5 hours every 6 months. Infusions may be interrupted or slowed as needed. ***Please use the following toll-free fax/phone numbers for Ocrevus enrollments. Fax: 1-844-847-8585; Phone: 1-855-821-0356***	Quantity: ☐ 2 vials ☐ Other: _____ Refills: _____
☐ Plegridy	☐ Pen Starter Pack (one 63 mcg pen & one 94 mcg pen) ☐ Pre-Filled Syringe Starter Pack (one 63 mcg pre-filled syringe & one 94 mcg pre-filled syringe)	Day 1: Administer 63 mcg/0.5mL SC; Day 15: Administer 94 mcg/0.5 mL SC	Quantity: 28-day supply Refills: _____
☐ Plegridy	☐ Pen Maintenance Pack (two 125 mcg pens) ☐ Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes)	☐ Administer 125 mcg/0.5 mL SC every 14 days. ☐ Other _____	Quantity: ☐ 28-day supply (1 pk) ☐ 84-day supply (3 pks) Refills: _____
☐ Rebif	☐ Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) ☐ Rebidose® Titration Pack (six 8.8 mcg prefilled autoinjectors & six 22 mcg prefilled autoinjectors)	Weeks 1-2: Inject 8.8 mcg SC three times a week Weeks 3-4: Inject 22 mcg SC three times a week	Quantity: 28-day supply (1 kit) Refills: _____
☐ Rebif ☐ Rebiject II	☐ 22 mcg prefilled syringe ☐ 44 mcg prefilled syringe ☐ Rebidose 22 mcg prefilled autoinjector ☐ Rebidose 44 mcg prefilled autoinjector	☐ Inject 44 mcg SC three times a week. ☐ Other _____	Quantity: ☐ 28-day supply (1 kit) ☐ 84-day supply (3 kits) Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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

X_____ X_____

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Medications S-Z
Multiple Sclerosis Enrollment Form
(Tecfidera®, Tysabri®, VUMERITY® Zeposia™)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Tecfidera	Titration Starter Pack (14 capsules of 120 mg & 46 capsules of 240 mg)	Take one 120 mg capsule by mouth twice a day for 7 days, followed by one 240 mg capsule by mouth twice a day.	Quantity: 30-day supply Refills: _____
☐ Tecfidera	☐ 120 mg capsules ☐ 240 mg capsules	☐ Take 240 mg by mouth twice a day. ☐ Other _____	Quantity: ☐ 7-day supply ☐ 30-day supply ☐ 90-day supply Refills: _____
☐ Tysabri	NA	Please complete an MS Touch®/Tysabri enrollment form and indicate CVS Specialty® as your preferred pharmacy. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255).	Quantity: 0 Refill: 0
☐ VUMERITY	231 mg capsule	☐ Take one 231 mg capsule twice a day by mouth for 7 days. Starting on Day 8, take 462 mg (two 231 mg capsules) twice a day by mouth. ☐ Other _____	Quantity ☐ 30-day supply ☐ 90-day supply Refills:_____
☐ Zeposia	Starter Kit (4 capsules of 0.23 mg, 3 capsules of 0.46 mg and one bottle containing 30 capsules of 0.92 mg)	Take 0.23 mg capsule once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7, then take 0.92 mg capsule once daily starting on day 8)	Quantity: 37-day supply Refill: 0
☐ Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	Take 0.23 mg capsule once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7	Quantity: 7-day supply Refill: 0
☐ Zeposia	0.92 mg capsules	Take 0.92 mg capsule once daily	Quantity ☐ 30-day supply ☐ 90-day supply Refills:_____

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

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PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

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Nursing Medications
Multiple Sclerosis Enrollment Form

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days) PORT/PICC – NS 10ml & Heparin 100units/ml 3-5ml, and/or 10ml sterile saline to access port a cath	Quantity:_____ Refills:_____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3mL (15-30kg/33-66lbs) ☐ Infant 0.1mL/0.1mL, 0.1mL (7.5-15kg/16.5-33lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity:_____ Refills:_____

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