Multiple Sclerosis Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com

Coram® CVS specialty infusion services

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
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: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax_____ 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 _____

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

Multiple Sclerosis Enrollment Form
Medications A-D

(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.	☐ 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	☐ 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: _____	☐ 30-day supply ☐ 90-day supply ☐ Other: _____ Refills: _____
☐ Betaseron	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 _____	☐ 28-day supply (1 kit of 14 vials) ☐ 84-day supply (3 kits of 14 vials) Refills: _____
☐ Betaject Lite Autoinjector	N/A	Betaject Lite can be ordered through Betaplus #1-800-788-1467	Quantity: 0 Refills: 0
☐ Copaxone	20 mg prefilled syringe	Inject 20 mg SC daily.	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits) Refills: _____
☐ Copaxone	40 mg prefilled syringe	Inject 40 mg SC three times a week.	☐ 28-day supply (12 syringes) ☐ 84-day supply (36 syringes) Refills: _____
☐ Autoject 2 for glass syringe injection device	N/A	Autoject 2 can be ordered through Shared Solutions #1-800-887-8100	Quantity: 0 Refills: 0
☐ Dalfampridine	10 mg extended release tablet	Take one tablet (10 mg) twice daily (approximately 12 hours apart)	☐ 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 120 mg twice a day orally for seven days. ☐ Other_____	Quantity: 7-day supply Refills: _____
☐ Dimethyl Fumarate	120 mg capsule	☐ Other_____	☐ 30-day supply ☐ 60-day supply ☐ Other: _____ Refills: _____
☐ Dimethyl Fumarate	240 mg capsule	☐ Administer 240 mg twice a day orally after day seven ☐ Other_____	☐ 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 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ Date: _____	**Prescriber's Signature: _____ Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Multiple Sclerosis Enrollment Form
Medications E-L

(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 _____	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits) Refills: _____
☐ Gilenya	0.5 mg	Take one capsule by mouth daily	☐ 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	☐ 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	☐ 30-day supply (1 kit) ☐ 90-day supply (3 kits) Refills:_____
☐ Kesimpta	20 mg/0.4 mL single-dose prefilled Sensoready pen	Loading Dose: ☐ Administer 20 mg subcutaneously at Week 0, 1, and 2 Maintenance Dose: ☐ Administer 20 mg subcutaneously once a month starting Week 4	☐ 28-day supply ☐ 84-day supply ☐ Other: _____ Refills:_____
☐ 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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Multiple Sclerosis Enrollment Form
Medications M
(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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Multiple Sclerosis Enrollment Form
Medications M-O
(Mayzent, Ocrevus)

Please Complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Mayzent Starter Pack (for 1 mg maintenance dose patients)	0.25 mg tablet	☐ Day 1: take 1 x 0.25 mg tablet by mouth once a day; Day 2: take 1 x 0.25 mg tablet by mouth once a day; Day 3: take 2 x 0.25 mg tablets by mouth once a day; Day 4: take 3 X 0.25 mg tablets once a day ☐ Other:_____	Quantity: 4-day supply Refill: 0
☐ Mayzent Starter Pack (for 2 mg maintenance dose patients)	0.25 mg tablet	☐ Day 1: take 1 x 0.25 mg tablet by mouth once a day; Day 2: take 1 x 0.25 mg tablet by mouth once a day; Day 3: take 2 x 0.25 mg tablets by mouth once a day; Day 4: take 3 X 0.25 mg tablets once a day; Day 5: take 5 X 0.25 mg tablets once a day. ☐ Other:_____	Quantity: 5-day supply Refill: 0
☐ Mayzent (maintenance prescription)	☐ 1 mg tablet ☐ 2 mg tablet	Administer one tablet by mouth once a day.	☐ 30-day supply ☐ 90-day supply Refills: _____
☐ 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 2 to 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: 1-855-592-6890; Phone: 1-866-526-4984***	☐ 2 vials ☐ Other: _____ 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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Prescriber's Signature: _____Date: _____	**Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

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Multiple Sclerosis Enrollment Form
Medications P-T

(Plegridy, Ponvory , Rebif, Ribiject II, Tecfidera)

Please Complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/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)	☐ Administer 63 mcg/0.5 mL SC on Day 1 followed by 94 mcg/0.5 mL SC on Day 15 ☐ Administer 63 mcg/0.5 mL IM on Day 1 followed by 94 mcg/0.5 mL IM on Day 15	Quantity: 28-day supply Refills: _____
☐ Plegridy	☐ Pen Maintenance Pack (two 125 mcg pens) for SC administration ☐ Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for SC administration ☐ Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for IM administration	☐ Administer 125 mcg/0.5 mL SC every 14 days ☐ Administer 125 mcg/0.5 mL IM every 14 days. ☐ Other _____	☐ 28-day supply (1 pk) ☐ 84-day supply (3 pks) Refills: _____
☐ Ponvory	Starter Pack	**Titration:** Day 1-2: Take 2 mg tablet by mouth once daily Day 3-4: Take 3 mg tablet by mouth once daily Day 5-6: Take 4 mg tablet by mouth once daily Day 7: Take 5 mg tablet by mouth once daily Day 8: Take 6 mg tablet by mouth once daily Day 9: Take 7 mg tablet by mouth once daily Day 10: Take 8 mg tablet by mouth once daily Day 11: Take 9 mg tablet by mouth once daily Day 12-14: Take 10 mg tablet by mouth once daily	Quantity: 14-day starter pack Refills: _____
☐ Ponvory	20 mg tablets	**Maintenance Dose** Day 15 and thereafter: Take 20 mg tablet by mouth once daily	☐ 30-day supply (30 tablets) ☐ 90-day supply (90 tablets) 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 _____	☐ 28-day supply (1 kit) ☐ 84-day supply (3 kits) 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 _____	☐ 7-day supply ☐ 30-day supply ☐ 90-day supply Refills: _____

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Multiple Sclerosis Enrollment Form
Medications T-Z
(Tysabri, VUMERITY, Zeposi)

Please Complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/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 _____	☐ 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	☐ 30-day supply ☐ 90-day supply Refills:_____

Nursing Medications

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 5 mL (Heparin 10 units/mL 3-5mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath	Quantity:_____ Refills:_____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ Infant 0.1 mL/0.1 mL, 0.1mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity:_____ 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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