

MULTIPLE SCLEROSIS ENROLLMENT FORM



DATE NEEDED: _____ MEDICATION/INJECTION START DATE: _____

Phone: 888.282.5166 Fax: 248.282.0471

Patient Information

Patient Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____
Daytime Phone: _____ Best Time to Call: _____
Cell Phone: _____ Best Time to Call: _____
E-Mail: _____
Patient's Primary Language: _____
Alternate Contact Name: _____
Alternate Contact Phone: _____
Ship to: Patient Physician Other: _____

Patient Insurance Information

Please copy front and back of medical and pharmacy insurance card and fax to Walgreens Specialty Pharmacy with this form. Medicare/Medicaid

Primary Insurer: _____
Telephone: _____
Policy ID #: _____ Group #: _____
Subscriber Name/Date of Birth: _____
Does this Plan Cover Prescription Drugs?: YES NO
Secondary Insurer: _____
Telephone: _____
Policy ID #: _____ Group #: _____
Subscriber Name/Date of Birth: _____
Does this Plan Cover Prescription Drugs?: YES NO
Employer: _____

PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize Walgreens Specialty Pharmacy to release any and all information it may have as necessary for Walgreens Specialty Pharmacy to (i) establish my eligibility for benefits; (ii) provide to me products, supplies or services; (iii) receive payment of benefits on my behalf; (iv) communicate with other healthcare providers regarding medical care provided, or to be provided, to me; (v) facilitate the provision of products, supplies, services or training required for my treatment through the product manufacturer, which may be used for promotional programs. I understand that my personal health information is subject to redisclosure. I have the right to revoke this authorization in writing at any time. I also have a right to receive a copy of this authorization. My refusal to sign this authorization will have no impact on receiving treatment from Walgreens Specialty Pharmacy. This authorization is valid for the duration of my treatment with Walgreens Specialty Pharmacy unless revoked in writing.

Patient Signature _____ Date _____

Patient Diagnosis Information

Please copy chart notes medication history and baseline lab results and fax to Walgreens Specialty Pharmacy with prescription.

Choose one of the following: New Restart Currently on Therapy (Start Date: _____) Onset of Illness: _____
Primary Diagnosis: RRMS SPMS PPMS PRMS Date of diagnosis: _____ ICD-9 code: 340 ICD-9 Other: _____
Previous Treatments: Avonex Betaseron Copaxone Rebif Methotrexate Other _____
Last MRI Date: _____ MRI Results: _____ Any MRI Changes: Yes No EDSS Baseline Score: _____
Current Symptoms: _____
Height: _____ Weight: _____ Date of Weight: _____ Allergies: _____
Other Medications Currently Taking: _____

Physician Information

Physician Name: _____ Site/Facility Name: _____
Street Address: _____ Specialty: _____
City: _____ St: _____ Zip: _____ Office Contact: _____ Telephone: _____
Fax: _____ Best Time to Call: _____ Office Contact E-Mail: _____
St. Lic. #: _____ DEA #: _____ NPI #: _____ UPIN #: _____
Office Hours: M - F _____ Sat: _____ Days Closed: _____

Prescription Information

Avonex® 30mcg/0.5ml prefilled syringe
 Avonex® 30mcg/vial (4 week pak) Directions: _____ Qty: _____ Refill x _____ Enroll in MS ActiveSource

Betaseron®
 Maintenance Therapy 0.3mg reconstitute and inject SQ every other day Qty: _____ Refill: x _____ Enroll in MS Pathways
 Dose Titration (Therapy Initiation) Weeks 1-2 0.0625 mg/0.25ml SQ every other day Weeks 5-6 0.1875 mg/0.75ml SQ every other day
Weeks 3-4 0.123 mg/0.5ml SQ every other day Weeks 7+ 0.25 mg/1ml SQ every other day

Copaxone® 20mg SQ Daily Qty: _____ Refill: x _____ Enroll in Shared Solutions®

Rebif® 22mcg Rebif® 44mcg Qty: _____ Refill: x _____ Enroll in MS LifeLines™

Rebif® Titration Pak: 8.8mcg SQ TIW - weeks 1-2 22mcg SQ TIW - weeks 3-4 44mcg SQ TIW - weeks 5+

Directions: _____ Qty: _____ Refill: x _____

Tysabri® Contact Tysabri Touch Program

H.P. Acthar® Gel Strength: _____ Qty: _____ Directions: _____ Refill x _____

Other: _____ Strength: _____ Qty: _____ Directions: _____ Refill x _____

Physician Signature: _____ Date: _____

Walgreens Specialty Pharmacy will confirm order upon receipt and follow up every 48 - 72 hours with insurance updates.

In order for a brand name product to be dispensed, the prescriber must handwrite "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space below

 Home Health Agency Nursing Visit Required Name of Agency: _____ Agency Phone Number: _____

FOR INTERNAL USE ONLY

Name: _____ Ext.: _____ Date: _____ Code: _____

Phone: 888.282.5166

Fax to 4D for Prior Authorization:

Fax: 248.282.0471