Multiple Sclerosis Orals and Injectables 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: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____
☐ **Check box if patient is enrolled in manufacturer copay assistance** **If yes, please provide ID# _____**

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: _____

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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: _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/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: _____
☐ 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: _____
☐ Fingolimod	0.5 mg	Take one capsule by mouth daily	☐ 30-day supply (1 bottle) ☐ 90-day supply (3 bottles) 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: _____

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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

	Month 1			
Check box	Weight	Dosing	Quantity	
☐	88 to <110 lb (40 to <50 kg)	1 tablet po daily for 4 days	4 pack #1	0 Refills
☐	110 to <132 lb (50 to <60 kg)	1 tablet po daily for 5 days	5 pack #1	0 Refills
☐	132 to <154 lb (60 to <70 kg)	2 tablets on day 1 then 1 tablet on days 2-5	6 pack #1	0 Refills
☐	154 to <176 lb (70 to <80 kg)	2 tablets on day 1 & 2 then 1 tablet on days 3-5	7 pack #1	0 Refills
☐	176 to <198 lb (80 to <90 kg)	2 tablets on 1-3 and then 1 tablet on day 4 & 5	8 pack #1	0 Refills
☐	198 to <220 lb (90 to <100 kg)	2 tablets on day 1-4 and then 1 tablet on day 5	9 pack #1	0 Refills
☐	220 to <242 lb (100 to <110 kg)	2 tablets on day 1-5	10 pack #1	0 Refills
☐	≥ 242 lb (110 kg and above)	2 tablets on day 1-5	10 pack #1	0 Refills
	Month 2			
	Weight	Dosing	Quantity	
☐	88 to <110 lb (40 to <50 kg)	1 tablet po daily for 4 days	4 pack #1	0 Refills
☐	110 to <132 lb (50 to <60 kg)	1 tablet po daily for 5 days	5 pack #1	0 Refills
☐	132 to <154 lb (60 to <70 kg)	2 tablets on day 1 then 1 tablet on days 2-5	6 pack #1	0 Refills
☐	154 to <176 lb (70 to <80 kg)	2 tablets on day 1 & 2 then 1 tablet on days 3-5	7 pack #1	0 Refills
☐	176 to <198 lb (80 to <90 kg)	2 tablets on day 1 & 2 then 1 tablet on days 3-5	7 pack #1	0 Refills
☐	198 to <220 lb (90 to <100 kg)	2 tablets on 1-3 and then 1 tablet on day 4 & 5	8 pack #1	0 Refills
☐	220 to <242 lb (100 to <110 kg)	2 tablets on day 1-4 and then 1 tablet on day 5	9 pack #1	0 Refills
☐	≥ 242 lb (110 kg and above)	2 tablets on day 1-5	10 pack #1	0 Refills

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☐ 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: _____
☐ 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: _____

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☐ 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: _____
☐ Teriflunomide	☐ 7 mg tablet ☐ 14 mg tablet	Take one tablet by mouth once a day.	☐ 30-day supply (1 bottle) ☐ 90-day supply (3 bottles) Refills: _____
☐ 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: _____

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