**BLUEGRASS PHARMACY** | MULTIPLE SCLEROSIS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the wellpartner Family

**FAX FORM TO:** 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

*Complete the following or include demographic sheet.*

## 1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

## 2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

## 3. INSURANCE INFORMATION

*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 ◯ Other:

Date of Diagnosis: / /

◯ G35 Multiple Sclerosis
- ◯ RRMS (Relapsing-Remitting)
- ◯ SPMS (Secondary-Progressive)
- ◯ PPMS (Primary-Progressive)
- ◯ PRMS (Progressive-Relapsing)

◯ Other (specify):

Has patient received injection training? ◯ Yes ◯ No

Height (in/cm): Weight (lb/kg):

Patient is: ◯ New to Therapy ◯ Restarting Therapy ◯ Currently on Therapy

If currently on therapy, start date of therapy: / /

Current Therapy: ◯ Aubagio ◯ Avonex ◯ Betaseron ◯ Copaxone ◯ Extavia ◯ Gilenya ◯ Novantrone ◯ Rebif ◯ Tecfidera ◯ Tysabri

Other Current Medications:
Prior or Failed Medications:
Allergies:

## 5. PRESCRIPTION INFORMATION

| Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ◯ Aubagio® (LD)* | (LD)* This is a limited distribution drug that requires additional handling. Please call (1.855.492.0817) for more information. | | | |
| ◯ Avonex® | ◯ 30 mcg prefilled syringe (PFS)<br>◯ 30 mcg pen (single dose)<br>◯ 30 mcg single dose vial | ◯ Inject 30 mcg intramuscularly once a week. | ◯ 4-week supply (1 kit)<br>◯ 12-week supply (3 kits)<br>◯ Other: | |
| ◯ Betaseron® | ◯ 0.3 mg | ◯ Inject 0.25 mg (1 ml) subcutaneously every other day<br>◯ Dose Titration:<br>• Weeks 1-2: Inject 0.0625 mg/0.25 ml subcutaneously QOD<br>• Weeks 3-4: Inject 0.125 mg/0.50 ml subcutaneously QOD<br>• Weeks 5-6: Inject 0.1875 mg/0.75 ml subcutaneously QOD<br>• Weeks 7+: Inject 0.25 mg/1 ml subcutaneously QOD<br>◯ Other: | ◯ 28-day supply (14 vials)<br>◯ 84-day supply (42 vials) | |
| ◯ Copaxone® | ◯ 20 mg PFS | ◯ Inject 20 mg subcutaneously daily | ◯ 30-day supply (1 kit)<br>◯ 90-day supply (3 kits) | |
| | ◯ 40 mg PFS | ◯ Inject 40 mg subcutaneously 3 times per week | ◯ 4-week supply (12 syringes)<br>◯ 12-week supply (36 syringes) | |
| ◯ Autoject 2® for glass syringe injection device | | Use as directed | 1 | PRN |
| ◯ Extavia® | ◯ 0.3 mg | ◯ Inject 0.25 mg (1 ml) subcutaneously every other day<br>◯ Dose Titration:<br>• Weeks 1-2: Inject 0.0625 mg/0.25 ml subcutaneously QOD<br>• Weeks 3-4: Inject 0.125 mg/0.50 ml subcutaneously QOD<br>• Weeks 5-6: Inject 0.1875 mg/0.75 ml subcutaneously QOD<br>• Weeks 7+: Inject 0.25 mg/1 ml subcutaneously QOD<br>◯ Other: | ◯ 30-day supply (1 kit)<br>◯ 90-day supply (3 kits) | |
| ◯ Gilenya™ | ◯ 0.5 mg | ◯ Take one 0.5 mg capsule by mouth once a day | ◯ 28-day supply (1 box)<br>◯ 84-day supply (3 boxes) | |
| ◯ Glatopa | ◯ 20 mg PFS | ◯ Inject 20 mg subcutaneously daily | ◯ 30-day supply (1 kit)<br>◯ 90-day supply (3 kits) | |
| ◯ Lemtrada (LD)* | (LD)* These are limited distribution drugs that require additional handling. Please call (1.855.492.0817) for more information. | | | |
| ◯ Plegridy (LD)* | | | | |
| ◯ Rebif® | ◯ Titration Pack (8.8 mcg/22 mcg)<br>◯ 22 mcg PFS<br>◯ 44 mcg PFS<br>◯ Rebidose® Titration Pack<br>◯ Rebidose® 22 mcg autoinjector<br>◯ Rebidose® 44 mcg autoinjector | ◯ Inject 8.8 mcg subcutaneously 3 times per week weeks 1-2, 22 mcg subcutaneously 3 times per week weeks 3-4<br>◯ Maintenance: Inject 22 mcg (0.5 ml) SQ 3 times per week<br>◯ Maintenance: Inject 44 mcg (0.5 ml) SQ 3 times per week<br>◯ Other: | ◯ 4-week supply (1 kit)<br>◯ 12-week supply (3 kits)<br>◯ Other: | |
| ◯ Tecfidera™ (LD)* | (LD)* These are limited distribution drugs that require additional handling. Please call (1.855.492.0817) for more information. | | | |
| ◯ Tysabri® (LD)* | | | | |
| ◯ Zinbryta (LD)* | | | | |
| ◯ Other: | | | | |

*Ancillary supplies and kits will be provided as needed for administration.*

## 6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE