Multiple Sclerosis Enrollment Form
Phone: 855-425-4085
Fax : 855-425-4096
ardonhealth.com

PATIENT INFORMATION

Patient Name: ____
Address: ____
City: ____ State: ____ Zip: ____
Primary Phone: ____ DOB: ____
Alternate Phone: ____ Gender: ☐ Male ☐ Female
E-mail: ____
Primary Language: ____
Height: ____ Weight: ____

PRESCRIBER INFORMATION

Prescriber's Name: ____
State License #: ____ NPI #: ____
DEA #: ____
Group or Hospital: ____
Address: ____
City, State Zip: ____ State: ____ Zip: ____
Phone: ____ Fax: ____
Contact Person: ____ Phone: ____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL

Need By Date: ____ **Ship to**: ☐ Patient ☐ Physician ☐ Other:

Date of Diagnosis: ____
Diagnosis: G35 Multiple Sclerosis
☐ Clinically Isolated Syndrome ☐ Relapsing-Remitting ☐ Secondary Progressive ☐ Primary Progressive
☐ Other (ICD-10 Code):
Number of Relapses Last Year:

Previous Disease-Modifying Therapy:

Current Medications:

Allergies: ____ **Is the patient new to therapy?** ☐ **Yes** ☐ **No**

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Aubagio	☐ 7mg ☐ 14mg	☐ Take 1 tab PO daily.	☐ 30	____
☐ Avonex PFS ☐ Avonex Pen	☐ 30mcg	☐ **Titration Dosing (PFS):** Week 1: Inject 7.5mcg IM. Week 2: Inject 15mcg IM. Week 3: Inject 22.5mcg IM. Week 4: Start injecting 30mcg IM once a week. ☐ Inject 30mcg IM once a week.	☐ 1 Kit = 4 PFS ☐ 1 Kit = 4 Pens	____
☐ Betaseron	☐ 0.3mg	☐ **Titration Dosing:** Weeks 1–2: Inject 0.0625mg (0.25mL) SQ QOD Weeks 3–4: Inject 0.125mg (0.5mL) SQ QOD. Weeks 5–6: Inject 0.1875mg (0.75mL) SQ QOD. Week 7: Start injecting 0.25mg (1mL) SQ QOD. ☐ Inject 0.25mg (1mL) SQ every other day.	☐ 1 Kit = 14 devices	____
☐ Copaxone PFS ☐ Glatopa PFS ☐ Glatiramer acetate PFS	☐ 20mg ☐ 40mg	☐ Inject 20mg SQ daily. ☐ Inject 40mg SQ 3 times a week. ☐ Other	☐ 1 Kit = 30 PFS ☐ 1 Kit = 12 PFS	____
☐ Dalfampridine	☐ 10mg tab	☐ Take 1 tablet PO twice daily approximately 12 hours apart.	☐ 60	____
☐ Extavia	☐ 0.3mg	☐ **Titration Dosing:** Weeks 1–2: Inject 0.0625mg (0.25mL) SQ QOD. Weeks 3–4: Inject 0.125mg (0.5mL) SQ QOD. Weeks 5–6: Inject 0.1875mg (0.75mL) SQ QOD. Week 7: Start injecting 0.25mg (1mL) SQ QOD. ☐ Inject 0.25mg (1mL) SQ every other day.	☐ 1 kit = 15 devices	____
☐ Gilenya	☐ 0.5mg Cap	☐ Take 1 cap PO daily.	☐ 30	____
☐ Mayzent	CYP2C9 Genotype *1/*1, *1/*2, and *2/*2 ☐ 2mg tab	☐ **Titration Dosing:** Please contact manufacturer (Alongside MS)	NA	NA
		☐ Take 2mg PO daily.	☐ 30	____
	CYP2C9 Genotype *1/*3 or *2/*3 ☐ 0.25mg tab	☐ **Titration Dosing (commercially insured):** Please contact manufacturer (Alongside MS)	NA	NA
		☐ **Titration Dosing (government insured):** 0.25mg PO day 1-2, 0.50mg day 3, 0.75mg day 4, followed by 1mg daily thereafter. ☐ Take 1mg PO daily.	☐ 112	____

x ____ PHYSICIAN SIGNATURE REQUIRED x ____

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

Ancillary supplies and kits provided as needed for administration

Date Needed: ____________ Medication Start Date: ____________

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PATIENT INFORMATION

Patient Name: ______
Address: ______
City: ______ State: ______ Zip: ______
Primary Phone: ______ DOB: ______
Alternate Phone: ______ Gender: ☐ Male ☐ Female
E-mail: ______
Primary Language: ______
Height: Weight:

PRESCRIBER INFORMATION

Prescriber's Name: ______
State License #: ______ NPI #: ______
DEA #: ______
Group or Hospital: ______
Address: ______
City, State Zip: ______ State: ______ Zip: ______
Phone: ______ Fax: ______
Contact Person: Phone:

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CLINICAL

Need By Date: **Ship to**: ☐ Patient ☐ Physician ☐ Other:

Date of Diagnosis: ☐ Clinically Isolated Syndrome ☐ Relapsing-Remitting ☐ Secondary Progressive ☐ Primary Progressive
Diagnosis: G35 Multiple Sclerosis ☐ Other (ICD-10 Code):
Number of Relapses Last Year:

Previous Disease-Modifying Therapy:

Current Medications:

Allergies: **Is the patient new to therapy?** ☐ **Yes** ☐ **No**

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refill
☐ Ocrevus	☐ 300mg/10mL	☐ **Initial Dose:** Infuse 300mg IV on day 1, followed by 300mg IV 2 weeks later. ☐ **Maintenance Dose:** Infuse 600mg IV every 6 months.	☐ 2 SDV	____
☐ Plegridy PFS ☐ Plegridy Autoinjector	☐ Titration Pack ☐ 125mcg/0.5mL	☐ **Titration Dose:** Inject 63mcg SQ on day 1, 94mcg on day 15, 125mcg on day 29 and every 14 days thereafter. ☐ Inject 125mcg SQ every 14 days.	☐ 1 Titration Kit = 2 Pen/PFS ☐ 2	____
☐ Rebif PFS ☐ Rebif Rebidose Autoinjector	☐ Titration Pack	☐ **Titration to 22 mcg dose** (PFS only): Weeks 1-2: Inject 4.4mcg SQ 3 times a week. Weeks 3-4: Inject 11mcg SQ 3 times a week. Week 5: Start injecting 22mcg SQ 3 times a week. ☐ **Titration to 44mcg dose:** Weeks 1–2: Inject 8.8mcg SQ 3 times a week. Weeks 3–4: Inject 22mcg SQ 3 times a week. Week 5: Start injecting 44mcg SQ 3 times a week.	☐ 1 Titration Kit = six 8.8mcg + six 22mcg Syringes or Autoinjectors	0
☐ Rebif PFS ☐ Rebif Rebidose Autoinjector	☐ 22mcg ☐ 44mcg	☐ Inject 22mcg SQ 3 times a week. ☐ Inject 44mcg SQ 3 times a week. ☐ Other	☐ 12	____
☐ Tecfidera	☐ Starter Kit ☐ 120mg DR cap (dispensed in multiples of #14) ☐ 240mg DR cap	☐ **Titration Dose:** Take 120mg PO twice daily for 7 days, then take 240mg twice daily thereafter. ☐ Take 240mg PO twice daily. ☐ Other	☐ 1 Starter Kit (60 caps) ☐ 60 ☐ Other ________	____
☐ Vumerity	☐ Starter Kit ☐ 231 mg DR cap	☐ **Titration Dose:** Take 231mg PO twice daily for 7 days, then take 462mg twice daily thereafte r. ☐ Take 462mg PO twice daily. ☐ Other	☐ 1 Starter Kit (106 caps) ☐ 120	____

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x ______________________ x ______________________

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PATIENT INFORMATION			PRESCRIBER INFORMATION	
Patient Name:			Prescriber's Name:	
Address:			State License #:	NPI #:
City:	State:	Zip:	DEA #:	
Primary Phone:	DOB:		Group or Hospital:	
Alternate Phone:	Gender: ☐ Male ☐ Female		Address:	
E-mail:			City, State Zip:	State: Zip:
Primary Language:			Phone:	Fax:
Height:	Weight:		Contact Person:	Phone:

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CLINICAL		
Need By Date:	**Ship to**: ☐ Patient ☐ Physician ☐ Other:	
Date of Diagnosis: **Diagnosis:** G35 Multiple Sclerosis	☐ Clinically Isolated Syndrome ☐ Relapsing-Remitting ☐ Secondary Progressive ☐ Primary Progressive ☐ Other (ICD-10 Code):	Number of Relapses Last Year:
Previous Disease-Modifying Therapy:		
Current Medications:		
Allergies:	**Is the patient new to therapy?** ☐ **Yes** ☐ **No**	

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Zeposia	☐ Titration Pack (7-day) ☐ Titration Pack (37-day)	☐ **Titration Dose**: 0.23mg PO day 1-4, 0.46mg day 5-7, followed by 0.92mg daily thereafter.	☐ 1 Titration Kit	NA
	☐ 0.92mg cap	☐ Take 0.92mg PO daily.	☐ 30	____

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x ______________________________ DISPENSE AS WRITTEN (Date)

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Date Needed: ______________ Medication Start Date: ______________

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