# Multiple Sclerosis Orals and Injectables Enrollment Form

CVS specialty®

**Fax Referral To:** 1-877-232-5455
**Address:** 3375 Koapaka Street, Suite D105, Honolulu, HI 96819

**Phone:** 1-808-254-2727
**NCPDP:** 1203417

**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):**

☐ G35.0 Initial manifestation of multiple sclerosis ☐ G35.1 Relapsing-remitting multiple sclerosis
☐ G35.2 Primary progressive multiple sclerosis ☐ G35.3 Secondary progressive multiple sclerosis
☐ G35.8 Other specified types of multiple sclerosis ☐ G35.9 Multiple sclerosis, unspecified
☐ Other Code: _____ Description _____

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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Patient Name: _____Patient DOB: _____Patient Phone:_____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Aubagio | ☐ 7 mg<br>☐ 14 mg | Take one tablet by mouth once a day. | ☐ 30-day supply (1 bottle)<br>☐ 90-day supply (3 bottles)<br>Refills: _____ |
| ☐ Avonex | ☐ 30 mcg prefilled syringe<br>☐ 30 mcg pen (single doses) | Inject 30 mcg intramuscularly once a week | ☐ 28-day supply (1 box)<br>☐ 84-day supply (3 kits)<br>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<br>☐ Other: _____ | ☐ 30-day supply<br>☐ 90-day supply<br>☐ Other: _____<br>Refills: _____ |
| ☐ Betaseron | 0.3 mg | ☐ Inject 0.25 mg (1mL) SC every other day.<br>☐ Dose Titration:<br>• Weeks 1-2: Inject 0.0625 mg/0.25 mL SC QOD;<br>• Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD;<br>• Weeks 5-6: Inject 0.1875 mg/0.75 mL SC QOD;<br>• Weeks 7+: Inject 0.25 mg/1 mL SC QOD<br>☐ Other _____ | ☐ 28-day supply (1 kit of 14 vials)<br>☐ 84-day supply (3 kits of 14 vials)<br>Refills: _____ |
| ☐ Betaject Lite Autoinjector | N/A | Betaject Lite can be ordered through Betaplus #1-800-788-1467 | Quantity: 0<br>Refills: 0 |
| ☐ Copaxone | 20 mg prefilled syringe | Inject 20 mg SC daily. | ☐ 30-day supply (1 kit)<br>☐ 90-day supply (3 kits)<br>Refills: _____ |
| ☐ Copaxone | 40 mg prefilled syringe | Inject 40 mg SC three times a week. | ☐ 28-day supply (12 syringes)<br>☐ 84-day supply (36 syringes)<br>Refills: _____ |
| ☐ Autoject 2 for glass syringe injection device | N/A | Autoject 2 can be ordered through Shared Solutions #1-800-887-8100 | Quantity: 0<br>Refills: 0 |
| ☐ Dalfampridine | 10 mg extended-release tablet | Take one tablet (10 mg) twice daily (approximately 12 hours apart) | ☐ 30-day supply<br>☐ 90-day supply<br>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<br>**Prescriber's Signature: _____Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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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**Please Complete Patient and Prescriber Information**

Patient Name: _____Patient DOB: _____Patient Phone:_____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Dimethyl Fumarate | Starter Pack<br>(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<br>Refills: _____ |
| ☐ Dimethyl Fumarate | 120 mg capsule | ☐ Administer 120 mg twice a day orally for seven days.<br>☐ Other_____ | Quantity: 7-day supply<br>Refills: _____ |
| ☐ Dimethyl Fumarate | 120 mg capsule | ☐ Other_____ | ☐ 30-day supply<br>☐ 60-day supply<br>☐ Other: _____<br>Refills: _____ |
| ☐ Dimethyl Fumarate | 240 mg capsule | ☐ Administer 240 mg twice a day orally after day seven<br>☐ Other_____ | ☐ 30-day supply<br>☐ 90-day supply<br>Refills: _____ |
| ☐ Fingolimod | 0.5 mg | Take one capsule by mouth daily | ☐ 30-day supply (1 bottle)<br>☐ 90-day supply (3 bottles)<br>Refills: _____ |
| ☐ Gilenya | 0.5 mg | Take one capsule by mouth daily | ☐ 30-day supply (1 bottle)<br>☐ 90-day supply (3 bottles)<br>Refills: _____ |
| ☐ Glatiramer Acetate | 40 mg<br>prefilled syringe | Inject 40 mg SC three times a week | ☐ 28-day supply (12 syringes)<br>☐ 84-day supply (36 syringes)<br>Refills: _____ |
| ☐ WhisperJECT Autoinjector device (1st fill only) | N/A | Use as directed | Quantity:1<br>Refills: 0 |
| ☐ Welcome Kit (1st fill only) | N/A | Use as directed | Quantity:1<br>Refills: 0 |
| ☐ Glatopa | 20 mg<br>prefilled syringe | Inject 20 mg SC daily | ☐ 30-day supply (1 kit)<br>☐ 90-day supply (3 kits)<br>Refills: _____ |
| ☐ Kesimpta | 20 mg/0.4 mL single-dose prefilled Sensoready pen | Loading Dose:<br>☐ Administer 20 mg subcutaneously at Week 0, 1, and 2<br>Maintenance Dose:<br>☐ Administer 20 mg subcutaneously once a month starting Week 4 | ☐ 28-day supply<br>☐ 84-day supply<br>☐ Other: _____<br>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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**Please Complete Patient and Prescriber Information**

Patient Name: _____Patient DOB: _____Patient Phone:_____

Patient Address: _____

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<br><br>Patient Weight:<br>___kg or ____lb<br><br>Treatment Course:<br><br>☐ Year 1<br><br>☐ Year 2 | Week 1:<br>4-pack; Quantity: _____<br>5-pack: Quantity: _____<br>6-pack; Quantity: _____<br>7-pack; Quantity: _____<br>8-pack; Quantity: _____<br>9-pack; Quantity: _____<br>10-pack; Quantity: _____<br>Week 5:<br>4-pack; Quantity: _____<br>5-pack: Quantity: _____<br>6-pack; Quantity: _____<br>7-pack; Quantity: _____<br>8-pack; Quantity: _____<br>9-pack; Quantity: _____<br>10-pack; Quantity: _____<br>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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## 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<br>☐ Other:_____ | Quantity: 4-day supply<br>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.<br>☐ Other: _____ | Quantity: 5-day supply<br>Refill: 0 |
| ☐ Mayzent (maintenance prescription) | ☐ 1 mg tablet<br>☐ 2 mg tablet | Administer one tablet by mouth once a day. | ☐ 30-day supply<br>☐ 90-day supply<br>Refills: _____ |
| ☐ Plegridy | ☐ Pen Starter Pack (one 63 mcg pen & one 94 mcg pen)<br>☐ 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<br>☐ 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<br>Refills: _____ |
| ☐ Plegridy | ☐ Pen Maintenance Pack (two 125 mcg pens) for SC administration<br>☐ Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for SC administration<br>☐ Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for IM administration | ☐ Administer 125 mcg/0.5 mL SC every 14 days<br>☐ Administer 125 mcg/0.5 mL IM every 14 days.<br>☐ Other _____ | ☐ 28-day supply (1 pk)<br>☐ 84-day supply (3 pks)<br>Refills: _____ |
| ☐ Ponvory | Starter Pack | **Titration:**<br>Day 1-2: Take 2 mg tablet by mouth once daily<br>Day 3-4: Take 3 mg tablet by mouth once daily<br>Day 5-6: Take 4 mg tablet by mouth once daily<br>Day 7: Take 5 mg tablet by mouth once daily<br>Day 8: Take 6 mg tablet by mouth once daily<br>Day 9: Take 7 mg tablet by mouth once daily<br>Day 10: Take 8 mg tablet by mouth once daily<br>Day 11: Take 9 mg tablet by mouth once daily<br>Day 12-14: Take 10 mg tablet by mouth once daily | Quantity: 14-day starter pack<br>Refills: _____ |
| ☐ Ponvory | 20 mg tablets | **Maintenance Dose**<br>Day 15 and thereafter: Take 20 mg tablet by mouth once daily | ☐ 30-day supply (30 tablets)<br>☐ 90-day supply (90 tablets)<br>Refills: _____ |

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|---|---|---|---|
| ☐ Rebif | ☐ Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes)<br>☐ 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<br>Weeks 3-4: Inject 22 mcg SC three times a week | Quantity: 28-day supply (1 kit)<br>Refills: _____ |
| ☐ Rebif<br>☐ Rebiject II | ☐ 22 mcg prefilled syringe<br>☐ 44 mcg prefilled syringe<br>☐ Rebidose 22 mcg prefilled autoinjector<br>☐ Rebidose 44 mcg prefilled autoinjector | ☐ Inject 44 mcg SC three times a week.<br>☐ Other _____ | ☐ 28-day supply (1 kit)<br>☐ 84-day supply (3 kits)<br>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<br>Refills: _____ |
| ☐ Tecfidera | ☐ 120 mg capsules<br>☐ 240 mg capsules | ☐ Take 240 mg by mouth twice a day.<br>☐ Other _____ | ☐ 7-day supply<br>☐ 30-day supply<br>☐ 90-day supply<br>Refills: _____ |
| ☐ Teriflunomide | ☐ 7 mg tablet<br>☐ 14 mg tablet | Take one tablet by mouth once a day. | ☐ 30-day supply (1 bottle)<br>☐ 90-day supply (3 bottles)<br>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.<br>☐ Other _____ | ☐ 30-day supply<br>☐ 90-day supply<br>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<br>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<br>Refill: 0 |
| ☐ Zeposia | 0.92 mg capsules | Take 0.92 mg capsule once daily | ☐ 30-day supply<br>☐ 90-day supply<br>Refills: _____ |

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