benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____
☐ NEW PATIENT ☐ CURRENT PATIENT

Multiple Sclerosis

PRESCRIBER INFORMATION PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____
DOB _____ SSN _____
Drug Allergies _____ ☐ Male ☐ Female
Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____
NPI# _____ Tax ID _____
Practice Name _____
Address _____ Suite _____
City _____ State _____ Zip _____
Office Phone _____ Fax _____
Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____ Secondary Insurance (if applicable) _____
Insurance Phone _____ Insurance Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis: ☐ G35 Multiple Sclerosis ☐ Other ICD 10 _____ Date Diagnosed: ___/___/___
New to therapy: ☐ Yes ☐ No Previous Treatment: _____
Date of Last MRI: ___/___/___ Number of Relapses in Past Year: _____

DRUG NAME	DOSAGE	DIRECTIONS FOR USE	QTY	REFILLS
☐ Ampyra (generic)	☐ 10mg Tablet	Take 1 tablet by mouth every 12 hours	30 day supply	
☐ Aubagio® Genzyme Limited Distribution	☐ 7mg	Take 1 tablet daily	28 day supply	
☐ Avonex®	☐ Vial ☐ Pen ☐ Prefilled syringe	☐ Titration: Inject Weekly IM as follows: 7.5mcg Week 1, 15mcg Week 2, 22.5mcg Week 3, 30mcg Week 4 and beyond ☐ Maintenance: Inject 30mcg IM once a week	28 day supply	
☐ Betaseron® Kit ☐ Extavia® Kit		☐ Titration: Inject every other day SubQ as follows: 0.0625mg (0.25mL) Weeks 1-2, 0.125mg (0.5mL) Weeks 3-4, 0.1875mg (0.75mL) Weeks 5-6, 0.25mg (1mL) Week 7 and thereafter ☐ Maintenance: Inject 0.25mg SubQ every other day	28/30 day supply	
☐ Copaxone® PFS ☐ Glatopa®	☐ 20mg ☐ 40mg	☐ Inject 20mg under the skin daily ☐ Inject 40mg under the skin 3 times each week	28/30daysupply	
☐ Gilenya®	0.5mg capsule	Take 1 capsule daily with or without food ☐ First dose observation needed	28 day supply	
☐ Ocrevus®	☐ 300mg Vial	☐ Induction: Infuse 300mg intravenously at week 0 and week 2 ☐ Maintenance: Infuse 600mg intravenously every 6 months	2	
☐ Rebif® ☐ Prefilled Syringe ☐ Rebidose	☐ Titration Kit ☐ 22mcg ☐ 44mcg	☐ Titration to 22mcg: Inject SubQ 3 times per week as follows: 4.4mcg Weeks 1-2, 11mcg Weeks 3-4, 22mcg Week 5 and after ☐ Inject 22mcg SubQ 3 times per week ☐ Titration to 44mcg: Inject SubQ 3 times per week as follows: 8.8mcg Weeks 1-2, 22mcg Weeks 3-4, 44mcg Week 5 and after ☐ Inject 44mcg SubQ 3 times per week	28 day supply	
☐ Tysabri®	☐ 300mg Vial	Infuse 300mg intravenously over 1 hour every 4 weeks	28 day supply	

☐ Enroll in Manufacturer Program/Nurse Training Patient Signature: _____ Date: ___/___/___
Supplies Needed: ☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other
☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training
Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____