MULTIPLE SCLEROSIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.WellDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

G35 Date of first demyelinating event: _____

Type: ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Secondary-progressive ☐ Primary-progressive ☐ Progressive-relapsing

Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):

Prior therapies: _____ Reason for discontinuation: _____

Therapy: ☐ New ☐ Reauthorization ☐ Other _____

Has pregnancy been excluded? (check one): ☐ No ☐ Yes

First dose observation date (anticipated/complete): _____ TB test date: _____ Result: _____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Aubagio® (teriflunomide) ☐ Enroll in MS One to One®	☐ 14mg tablet ☐ 7mg tablet	☐ Take 1 tablet by mouth daily	☐ 30-day supply	_____
Avonex® (interferon beta-1a) ☐ Enroll in Above MS™	☐ 30mcg Prefilled Syringe 25G 1″ Needles ☐ 30mcg Avonex Pen (single dose)	☐ Inject 30mcg intramuscularly every week	☐ 4-week supply (1 kit)	_____
Betaseron® (interferon beta-1b) ☐ Enroll in BETAPLUS®	0.3mg	☐ Inject 0.25mg (1ml) Sub-Q every other day ☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml Sub-Q QOD • Weeks 3-4: Inject 0.125mg/0.50ml Sub-Q QOD • Weeks 5-6: Inject 0.1875mg/0.75 Sub-Q QOD • Weeks 7+: Inject 0.25mg/1ml Sub-Q QOD ☐ Other: _____	☐ 28-day supply (1 kit of 14 vials) ☐ Other: _____	_____
Copaxone® (glatiramer) ☐ Enroll in Shared Solutions® ☐ Enroll in Mylan MS ADVOCATE®	☐ 20mg Prefilled Syringe ☐ 40mg Prefilled Syringe	☐ Inject 20mg Sub-Q daily ☐ Inject 40mg Sub-Q 3 times weekly	☐ 30-day supply (1 kit)	_____
Extavia® (interferon beta-1b) ☐ Enroll in EXTAVIA® Go	0.3mg	☐ Inject 0.25mg (1ml) Sub-Q every other day ☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml Sub-Q QOD • Weeks 3-4: Inject 0.125mg/0.50ml Sub-Q QOD • Weeks 5-6: Inject 0.1875mg/0.75 Sub-Q QOD • Weeks 7+: Inject 0.25mg/1ml Sub-Q QOD ☐ Other: _____	☐ 30-day supply (1 kit)	_____
Gilenya™ (fingolimod) ☐ Enroll in Gilenya® Go	☐ 0.25 mg ☐ 0.5 mg	☐ Take one 0.25 mg capsule every day ☐ Take one 0.5 mg capsule every day	☐ 28-day supply ☐ 30-day supply ☐ Other: _____	_____
Glatopa™ (glatiramer) ☐ Enroll in GlatopaCare®	☐ 20mg Prefilled Syringe ☐ 40mg Prefilled Syringe	☐ Inject 20mg Sub-Q daily ☐ Inject 40mg Sub-Q 3 times weekly	30-day supply (1 kit)	_____
Rebif® (interferon beta-1a) ☐ Enroll in MSLifelines®	☐ Titration Pack (six 8.8mcg & six 22mcg prefilled syringes) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe ☐ Titration Pack Rebidose (six 8.8 mcg pre-filled autoinjectors and six 22 mcg pre-filled autoinjectors) ☐ Rebidose® 22mcg Prefilled Autoinjector ☐ Rebidose® 44mcg Prefilled Autoinjector	☐ Inject 8.8mcg Sub-Q three times a week weeks 1-2, 22mcg Sub-Q three times a week weeks 3-4, and 44mcg Sub-Q three times a week weeks 5+ ☐ Inject 44mcg Sub-Q three times a week ☐ Other: _____	☐ 4-week supply (1 kit) ☐ Other: _____	_____
Other				_____

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LIMITED DISTRIBUTION DRUGS

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Ampyra® (dalfampridine ER) ☐ Enroll in AMPYRA Patient Support Services	☐ 10mg ER tablet	☐ Take 1 tablet (10mg) every 12 hours	☐ 30-day supply	_____
Lemtrada® (alemtuzumab) ☐ Enroll in MS One to One®	☐ 12mg/1.2mL Single Dose Vial	☐ Infuse 12mg IV daily for 5 consecutive days ☐ Infuse 12mg IV daily for 3 consecutive days	☐	_____
Mavenclad® (cladribine) ☐ Enroll in MSLifelines®	☐ 10mg tablet	☐ Please attach separate prescription		_____
Mayzent® (siponimod) ☐ Enroll in Alongside MS™	☐ 0.25mg tablet ☐ 2mg tablet	☐ Please attach separate prescription		_____
Ocrevus™ (ocrelizumab) ☐ Enroll in OCREVUS CONNECTS®	☐ 300mg/10mL Single Dose Vial	☐ Infuse 300mg IV as a single dose, followed by 300mg IV infusion 2 weeks later ☐ Infuse 600mg IV every 6 months	☐ 2 vials	_____
Plegridy™ (peginterferon beta-1a) ☐ Enroll in Above MS™	☐ 125mcg Prefilled Syringe ☐ 125 mcg Plegridy Pen ☐ Plegridy Pen starter pack (One 63mcg and one 94mcg) ☐ Starter Pack prefilled syringes (One 63mcg and one 94mcg)	☐ Inject 125mcg Sub-Q every two weeks ☐ Dose titration: Inject • 63mcg SUB-Q on day 1 • 94mcg SUB-Q on day 15 • 125mcg SUB-Q on day 29	☐ 28-day supply (1 kit)	_____
Tecfidera® (dimethyl fumarate) ☐ Enroll in Above MS™	☐ 30-Day Starter Pack (14 capsules of 120mg & 46 capsules of 240mg) ☐ 120mg DR capsule ☐ 240mg DR capsule	☐ Take 120mg by mouth 2 times daily for 7 days then 240mg by mouth 2 times daily ☐ Take 240mg by mouth 2 times daily ☐ Other:_____	☐ 30-day Starter Pack ☐ 30-day supply	_____
Tysabri® (natalizumab) ☐ Enroll in Above MS™	☐ 300mg/15mL Single Dose Vial	☐ Infuse 300mg IV every 4 weeks	☐ 28-day supply	_____
Other				_____

PRESCRIBER INFORMATION

INJECTION TRAINING: OFFICE TO COORDINATE WELLDYNE SPECIALTY TO COORDINATE

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that WellDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written