

Multiple Sclerosis Orals and Injectables Enrollment Form



Fax Referral To: 1-800-323-2445 Phone: 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com



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)*

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 Multiple Sclerosis (MS) Other Code: _____ Description: _____

If MS, please indicate type: Primary progressive MS (PPMS)
 Relapsing-remitting MS (RRMS)
 Progressive-relapsing MS (PRMS)
 Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? Yes No
 First clinical episode of MS; If so, does the patient have MRI features consistent with MS? Yes No

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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<input type="checkbox"/> Aubagio	<input type="checkbox"/> 7 mg <input type="checkbox"/> 14 mg	Take one tablet by mouth once a day.	<input type="checkbox"/> 30-day supply (1 bottle) <input type="checkbox"/> 90-day supply (3 bottles) Refills: _____
<input type="checkbox"/> Avonex	<input type="checkbox"/> 30 mcg prefilled syringe <input type="checkbox"/> 30 mcg pen (single doses)	Inject 30 mcg intramuscularly once a week	<input type="checkbox"/> 28-day supply (1 box) <input type="checkbox"/> 84-day supply (3 kits) Refills: _____
<input type="checkbox"/> Bafiertam	95 mg capsule	<input type="checkbox"/> 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 <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Betaseron	0.3 mg	<input type="checkbox"/> Inject 0.25 mg (1mL) SC every other day. <input type="checkbox"/> Dose Titration: • Weeks 1-2: Inject 0.0625 mg/0.25 mL SC QOD; • Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD; • Weeks 5-6: Inject 0.1875 mg/0.75 mL SC QOD; • Weeks 7+: Inject 0.25 mg/1 mL SC QOD <input type="checkbox"/> Other _____	<input type="checkbox"/> 28-day supply (1 kit of 14 vials) <input type="checkbox"/> 84-day supply (3 kits of 14 vials) Refills: _____
<input type="checkbox"/> Betaject Lite Autoinjector	N/A	Betaject Lite can be ordered through Betaplus #1-800-788-1467	Quantity: 0 Refills: 0
<input type="checkbox"/> Copaxone	20 mg prefilled syringe	Inject 20 mg SC daily.	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits) Refills: _____
<input type="checkbox"/> Copaxone	40 mg prefilled syringe	Inject 40 mg SC three times a week.	<input type="checkbox"/> 28-day supply (12 syringes) <input type="checkbox"/> 84-day supply (36 syringes) Refills: _____
<input type="checkbox"/> Autoject 2 for glass syringe injection device	N/A	Autoject 2 can be ordered through Shared Solutions #1-800-887-8100	Quantity: 0 Refills: 0
<input type="checkbox"/> Dalfampridine	10 mg extended-release tablet	Take one tablet (10 mg) twice daily (approximately 12 hours apart)	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply 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 Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible 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	

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 above, 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.

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<input type="checkbox"/> Dimethyl Fumarate	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 Refills: _____
<input type="checkbox"/> Dimethyl Fumarate	120 mg capsule	<input type="checkbox"/> Administer 120 mg twice a day orally for seven days. <input type="checkbox"/> Other _____	Quantity: 7-day supply Refills: _____
<input type="checkbox"/> Dimethyl Fumarate	120 mg capsule	<input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 60-day supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Dimethyl Fumarate	240 mg capsule	<input type="checkbox"/> Administer 240 mg twice a day orally after day seven <input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____
<input type="checkbox"/> Extavia <input type="checkbox"/> Extavia Auto-Injector II	0.3 mg	<input type="checkbox"/> Inject 0.25 mg (1 mL) SC every other day. <input type="checkbox"/> Dose Titration: • Weeks 1-2: Inject 0.0625 mg/0.25 mL SC QOD • Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD • Weeks 5-6: Inject 0.1875 mg/0.75 mL SC QOD • Weeks 7+: Inject 0.25 mg/1 mL SC QOD <input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits) Refills: _____
<input type="checkbox"/> Fingolimod	0.5 mg	Take one capsule by mouth daily	<input type="checkbox"/> 30-day supply (1 bottle) <input type="checkbox"/> 90-day supply (3 bottles) Refills: _____
<input type="checkbox"/> Gilenya	0.5 mg	Take one capsule by mouth daily	<input type="checkbox"/> 30-day supply (1 bottle) <input type="checkbox"/> 90-day supply (3 bottles) Refills: _____
<input type="checkbox"/> Glatiramer Acetate	40 mg prefilled syringe	Inject 40 mg SC three times a week	<input type="checkbox"/> 28-day supply (12 syringes) <input type="checkbox"/> 84-day supply (36 syringes) Refills: _____
<input type="checkbox"/> WhisperJECT Autoinjector device (1st fill only)	N/A	Use as directed	Quantity: 1 Refills: 0
<input type="checkbox"/> Welcome Kit (1st fill only)	N/A	Use as directed	Quantity: 1 Refills: 0
<input type="checkbox"/> Glatopa	20 mg prefilled syringe	Inject 20 mg SC daily	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits) Refills: _____
<input type="checkbox"/> Kesimpta	20 mg/0.4 mL single-dose prefilled Sensoready pen	Loading Dose: <input type="checkbox"/> Administer 20 mg subcutaneously at Week 0, 1, and 2 Maintenance Dose: <input type="checkbox"/> Administer 20 mg subcutaneously once a month starting Week 4	<input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> Other: _____ Refills: _____

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<input type="checkbox"/> Mavenclad	10 mg tablet	Please see below for Week 1 and Week 5 dosing chart Patient Weight: ___ kg or ___ lb Treatment Course: <input type="checkbox"/> Year 1 <input type="checkbox"/> Year 2	Week 1: 4-pack; Quantity: _____ 5-pack; Quantity: _____ 6-pack; Quantity: _____ 7-pack; Quantity: _____ 8-pack; Quantity: _____ 9-pack; Quantity: _____ 10-pack; Quantity: _____ Week 5: 4-pack; Quantity: _____ 5-pack; Quantity: _____ 6-pack; Quantity: _____ 7-pack; Quantity: _____ 8-pack; Quantity: _____ 9-pack; Quantity: _____ 10-pack; Quantity: _____ Refills: 0

Number of MAVENCLAD (cladribine) 10 mg tablets per week

Month 1			
Check box	Weight	Dosing	Quantity
<input type="checkbox"/>	88 to <110 lb (40 to <50 kg)	1 tablet po daily for 4 days	4 pack #1 0 Refills
<input type="checkbox"/>	110 to <132 lb (50 to <60 kg)	1 tablet po daily for 5 days	5 pack #1 0 Refills
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	220 to <242 lb (100 to <110 kg)	2 tablets on day 1-5	10 pack #1 0 Refills
<input type="checkbox"/>	≥ 242 lb (110 kg and above)	2 tablets on day 1-5	10 pack #1 0 Refills
Month 2			
Check box	Weight	Dosing	Quantity
<input type="checkbox"/>	88 to <110 lb (40 to <50 kg)	1 tablet po daily for 4 days	4 pack #1 0 Refills
<input type="checkbox"/>	110 to <132 lb (50 to <60 kg)	1 tablet po daily for 5 days	5 pack #1 0 Refills
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	≥ 242 lb (110 kg and above)	2 tablets on day 1-5	10 pack #1 0 Refills

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<input type="checkbox"/> Mayzent Starter Pack (for 1 mg maintenance dose patients)	0.25 mg tablet	<input type="checkbox"/> 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 <input type="checkbox"/> Other: _____	Quantity: 4-day supply Refill: 0
<input type="checkbox"/> Mayzent Starter Pack (for 2 mg maintenance dose patients)	0.25 mg tablet	<input type="checkbox"/> 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. <input type="checkbox"/> Other: _____	Quantity: 5-day supply Refill: 0
<input type="checkbox"/> Mayzent (maintenance prescription)	<input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet	Administer one tablet by mouth once a day.	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____
<input type="checkbox"/> Plegridy	<input type="checkbox"/> Pen Starter Pack (one 63 mcg pen & one 94 mcg pen) <input type="checkbox"/> Pre-Filled Syringe Starter Pack (one 63 mcg pre-filled syringe & one 94 mcg pre-filled syringe)	<input type="checkbox"/> Administer 63 mcg/0.5 mL SC on Day 1 followed by 94 mcg/0.5 mL SC on Day 15 <input type="checkbox"/> 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 Refills: _____
<input type="checkbox"/> Plegridy	<input type="checkbox"/> Pen Maintenance Pack (two 125 mcg pens) for SC administration <input type="checkbox"/> Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for SC administration <input type="checkbox"/> Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for IM administration	<input type="checkbox"/> Administer 125 mcg/0.5 mL SC every 14 days <input type="checkbox"/> Administer 125 mcg/0.5 mL IM every 14 days. <input type="checkbox"/> Other _____	<input type="checkbox"/> 28-day supply (1 pk) <input type="checkbox"/> 84-day supply (3 pks) Refills: _____
<input type="checkbox"/> Ponvory	Starter Pack	Titration: Day 1-2: Take 2 mg tablet by mouth once daily Day 3-4: Take 3 mg tablet by mouth once daily Day 5-6: Take 4 mg tablet by mouth once daily Day 7: Take 5 mg tablet by mouth once daily Day 8: Take 6 mg tablet by mouth once daily Day 9: Take 7 mg tablet by mouth once daily Day 10: Take 8 mg tablet by mouth once daily Day 11: Take 9 mg tablet by mouth once daily Day 12-14: Take 10 mg tablet by mouth once daily	Quantity: 14-day starter pack Refills: _____
<input type="checkbox"/> Ponvory	20 mg tablets	Maintenance Dose Day 15 and thereafter: Take 20 mg tablet by mouth once daily	<input type="checkbox"/> 30-day supply (30 tablets) <input type="checkbox"/> 90-day supply (90 tablets) Refills: _____

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<input type="checkbox"/> Rebif	<input type="checkbox"/> Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) <input type="checkbox"/> 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 Weeks 3-4: Inject 22 mcg SC three times a week	Quantity: 28-day supply (1 kit) Refills: _____
<input type="checkbox"/> Rebif <input type="checkbox"/> Rebiject II	<input type="checkbox"/> 22 mcg prefilled syringe <input type="checkbox"/> 44 mcg prefilled syringe <input type="checkbox"/> Rebidose 22 mcg prefilled autoinjector <input type="checkbox"/> Rebidose 44 mcg prefilled autoinjector	<input type="checkbox"/> Inject 44 mcg SC three times a week. <input type="checkbox"/> Other _____	<input type="checkbox"/> 28-day supply (1 kit) <input type="checkbox"/> 84-day supply (3 kits) Refills: _____
<input type="checkbox"/> 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 Refills: _____
<input type="checkbox"/> Tecfidera	<input type="checkbox"/> 120 mg capsules <input type="checkbox"/> 240 mg capsules	<input type="checkbox"/> Take 240 mg by mouth twice a day. <input type="checkbox"/> Other _____	<input type="checkbox"/> 7-day supply <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____
<input type="checkbox"/> Teriflunomide	<input type="checkbox"/> 7 mg tablet <input type="checkbox"/> 14 mg tablet	Take one tablet by mouth once a day.	<input type="checkbox"/> 30-day supply (1 bottle) <input type="checkbox"/> 90-day supply (3 bottles) Refills: _____
<input type="checkbox"/> VUMERITY	231 mg capsule	<input type="checkbox"/> 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. <input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____
<input type="checkbox"/> 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 Refill: 0
<input type="checkbox"/> 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 Refill: 0
<input type="checkbox"/> Zeposia	0.92 mg capsules	Take 0.92 mg capsule once daily	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____

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