

Multiple Sclerosis

Enrollment Form

Date: _____
 Patient Name: _____
 Date of Birth: _____
 Diagnosis Date: _____

TwelveStone Health Partners

Fax Referral To:
(800) 223-4063

Direct Phone: (615) 278-3350
 Toll Free: (844) 893-0012



PREVIOUS ADMINISTRATION OF PRESCRIBED MULTIPLE SCLEROSIS THERAPY

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last infusion/injection date: _____	<input type="checkbox"/> Physician's office <input type="checkbox"/> TwelveStone Home Infusion
Next infusion/injection date: _____	<input type="checkbox"/> TwelveStone Infusion Suite <input type="checkbox"/> Enroll in Manufacturer Nurse Training
	Desired start date: _____

DIAGNOSIS

Description

Multiple Sclerosis - Other/Supporting Diagnosis
 ___ Relapsing Remitting ___ Clinically Isolated Syndrome
 ___ Primary Progressive ___ Secondary Progressive

ICD-10 Code

G35
 Other ICD 10: _____

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

This signed order form History and Physical Patient Demographics and Insurance Clinical progress notes- relevant labs with dates, etc.
 Number of relapses in past year: _____ Pregnant, Nursing or Planning Pregnancy? ___Yes___No Prior Failed Medication: ___

Yes___No
 Last MRI Date: _____ Previously treated for this condition? ___Yes___No Medication _____
 Any MRI changes? ___Yes___No Currently on therapy? ___Yes___No Duration of Treatment _____
 Reason for DC _____

First clinical episode of MS? ___Yes___No; if yes are MRI features consistent with MS? ___Yes___No Will current therapy be DC'd prior to starting new therapy? ___
 Yes___No: DC date _____
 Patient Weight: _____ Kg/Lbs Height: _____ Inches/CM BSA: _____ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Avonex	<input type="checkbox"/> Pen	<input type="checkbox"/> Titration - (PFS only and requires Avostartgrip kit) Inject IM 7.5mcg week 1, 15mcg week 2, 22.5mcg week 3, and 30mcg weekly thereafter.	28 day	0
	<input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Maintenance - Inject IM 30mcg weekly	28 day	
<input type="checkbox"/> Betaseron	<input type="checkbox"/> 0.3 mg	<input type="checkbox"/> Titration – Inject 0.25 ml SQ every other day for weeks 1-2, 0.5ml weeks 3-4, 0.75 ml weeks 5-6, and 1 ml week 7 and thereafter	56 day	
		<input type="checkbox"/> Inject 1ml every other day	28 day	
<input type="checkbox"/> Copaxone	<input type="checkbox"/> 20 mg PFS	<input type="checkbox"/> Inject SQ once daily		
	<input type="checkbox"/> 40 mg PFS	<input type="checkbox"/> Inject SQ 3 times weekly at least 48 hours apart, on the same 3 days each week		
<input type="checkbox"/> Dalfampridine (Ampyra)		Take by mouth twice daily 12 hrs apart		
<input type="checkbox"/> Dimethyl fumarate (Tecfidera)	<input type="checkbox"/> 14 x 120mg capsules	<input type="checkbox"/> Induction – Take 120mg by mouth twice daily for 7 days, then take 240mg twice daily		0
	<input type="checkbox"/> 46 x 240mg capsules	<input type="checkbox"/> Maintenance – Take 1 capsule (240mg) by mouth twice a day		
<input type="checkbox"/> Extavia	0.3 mg	<input type="checkbox"/> Titration – Inject 0.25 ml SQ every other day for weeks 1-2, 0.5ml weeks 3-4, 0.75 ml weeks 5-6, and 1 ml week 7 and thereafter	56 day	0
		<input type="checkbox"/> Inject 1ml every other day	28 day	
<input type="checkbox"/> Gilenya	0.5 mg capsule	Take 1 tablet daily		
<input type="checkbox"/> Glatopa	<input type="checkbox"/> 20 mg PFS	<input type="checkbox"/> Inject SQ once daily		
	<input type="checkbox"/> 40 mg PFS	<input type="checkbox"/> Inject SQ 3 times weekly (inject on the same days of each week)	28 day	

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Kesimpta	<input type="checkbox"/> 20mg/0.4ml PF Pen <input type="checkbox"/> 20mg/0.4ml PF Syringe	Induction – Inject 20mg SQ on week 0, 1, and 2 Maintenance – Inject 20mg SQ once monthly starting on week 4	28 day	
<input type="checkbox"/> Ocrevus	300mg vial	<input type="checkbox"/> Start – Infuse IV over 2.5 hours 300mg day 1 and day 15. <input type="checkbox"/> Maintenance – Infuse 600mg IV over 3.5 hours every 6 months	6 month	
<input type="checkbox"/> Plegridy	<input type="checkbox"/> Starter Pack PFS <input type="checkbox"/> Starter Pack Pen <input type="checkbox"/> 125mcg PFS <input type="checkbox"/> 125mcg Pen	<input type="checkbox"/> Titration - Inject 63mcg SQ on day 1, 94mcg SQ on day 15, and 125mcg SQ on day 29 <input type="checkbox"/> Maintenance - Inject 125mg SQ every 14 days		
<input type="checkbox"/> Rebif	<input type="checkbox"/> PFS Titration Kit <input type="checkbox"/> Rebidose Titration Kit ----- <input type="checkbox"/> PFS 22mcg <input type="checkbox"/> PFS 44mcg <input type="checkbox"/> Rebidose 22mcg <input type="checkbox"/> Rebidose 44mcg	<input type="checkbox"/> Inject SQ 3 times weekly – 4.4mcg weeks 1-2, 11mcg weeks 3-4, 22mcg week 5 and thereafter <input type="checkbox"/> Inject SQ 3 times weekly – 8.8mcg weeks 1-2, 22mcg weeks 3-4, 44mcg week 5 and thereafter ----- <input type="checkbox"/> Inject SQ 3 times weekly		
<input type="checkbox"/> Vumerity	231mg Capsules	<input type="checkbox"/> Induction – Take 1 capsule (231mg) twice daily for 7 days then take 2 capsules (462mg) twice daily thereafter ----- <input type="checkbox"/> Maintenance – Take 2 capsules (462mg) twice daily	Starter dose bottle	
<input type="checkbox"/> Zeposia	<input type="checkbox"/> 7 Day Starter Pack <input type="checkbox"/> 37 Day Starter Kit <input type="checkbox"/> 0.92 mg Capsule	<input type="checkbox"/> Starter – Take 0.23mg daily on Days 1-4, take 0.46mg daily on Days 5-7, and 0.92mg daily thereafter <input type="checkbox"/> Maintenance – Take 1 capsule (0.92mg) by mouth daily		

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone: _____ Physician's NPI: _____	Dispense as written: _____ Date: _____
Physician's Fax: _____ Physician's Address: _____	Printed name: _____ Substitution allowed: _____

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