

**Multiple Sclerosis
Enrollment Form A-E**

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



Date: _____

Patient Name: _____

Date of Birth: _____

DIAGNOSIS

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Relapsing Remitting | <input type="checkbox"/> Clinically Isolated Syndrome | <input type="checkbox"/> G35: _____ |
| <input type="checkbox"/> Primary Progressive | <input type="checkbox"/> Secondary Progressive | <input type="checkbox"/> Other: _____ |

PREVIOUS ADMINISTRATION

Is the patient currently on therapy? Yes No

If YES, please provide the following information:

Medication: _____
 Last Dose Date: _____
 Next Dose Date: _____
 Duration of Treatment: _____
 Reason for Discontinuing: _____ DC Date: _____
 Will Current Therapy be DC'd prior to starting new therapy: Yes No

If NO, please indicate desired location for delivery of first dose:

- Physician's Office
 Patient's Home
 Enroll in Manufacturer Nurse Training
 Desired Start Date: _____

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- (Please attach documents as needed)

- | | |
|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Patient Demographics and Insurance Information |
| <input type="checkbox"/> This Signed Order Form | <input type="checkbox"/> Pregnant, Nursing or Planning Pregnancy: Yes <u> </u> No <u> </u> |
| <input type="checkbox"/> Prior Failed Medication: _____ | <input type="checkbox"/> Clinical Progress Notes, Relevant Labs with dates, etc. |
| <input type="checkbox"/> Number of Relapses in Past Year: _____ | |

- Last MRI Date: _____ Previously Treated for this Condition: Yes No Any MRI Changes: Yes No
 First Clinical Episode of MS: Yes No -If YES, are MRI features consistent with MS: Yes No
 Patient Weight: _____ Kg/Lbs Patient Height: _____ Inches/CM BSA: _____ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	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"/> 0.3mg Vial	<input type="checkbox"/> Titration- Inject 0.25ml SQ every other day for weeks 1-2, 0.5ml weeks 3-4, 0.75ml weeks 5-6, and 1ml week 7 and thereafter	56 Day	
		<input type="checkbox"/> Inject 1ml SQ every other day	28 Day	
<input type="checkbox"/> COPAXONE	<input type="checkbox"/> 20mg PFS	<input type="checkbox"/> Inject SQ once daily		
	<input type="checkbox"/> 40mg 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)	<input type="checkbox"/> 10mg Tablet	<input type="checkbox"/> Take one tablet by mouth twice daily 12 hours apart		
<input type="checkbox"/> DIMETHYLFUMARATE (Tecfidera)	<input type="checkbox"/> 30-day Starter Pack (14 x 120mg Capsules) (46 x 240mg Capsules)	<input type="checkbox"/> Titration- Take 120mg by mouth twice daily for 7 days, then take 240mg twice daily		0
	<input type="checkbox"/> 14 x 120mg capsules	<input type="checkbox"/> Maintenance- Take one capsule (240mg) by mouth twice daily		
	<input type="checkbox"/> 60 x 240mg capsules			
<input type="checkbox"/> EXTAVIA	<input type="checkbox"/> 0.3mg Vial	<input type="checkbox"/> Titration- Inject 0.25ml SQ every other day for weeks 1-2, 0.5ml weeks 3-4, 0.75ml weeks 5-6, and 1ml week 7 and thereafter	56 Day	0
		<input type="checkbox"/> Inject 1ml SQ every other day	28 Day	

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

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

**Multiple Sclerosis
Enrollment Form G-P**

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



Date: _____

Patient Name: _____

Date of Birth: _____

DIAGNOSIS

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Relapsing Remitting | <input type="checkbox"/> Clinically Isolated Syndrome | <input type="checkbox"/> G35: _____ |
| <input type="checkbox"/> Primary Progressive | <input type="checkbox"/> Secondary Progressive | <input type="checkbox"/> Other: _____ |

PREVIOUS ADMINISTRATION

Is the patient currently on therapy? Yes No

If YES, please provide the following information:

Medication: _____
 Last Dose Date: _____
 Next Dose Date: _____
 Duration of Treatment: _____
 Reason for Discontinuing: _____ DC Date: _____
 Will Current Therapy be DC'd prior to starting new therapy: Yes No

If NO, please indicate desired location for delivery of first dose:

- Physician's Office
 Patient's Home
 Enroll in Manufacturer Nurse Training
 Desired Start Date: _____

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- (Please attach documents as needed)

- | | |
|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Patient Demographics and Insurance Information |
| <input type="checkbox"/> This Signed Order Form | <input type="checkbox"/> Pregnant, Nursing or Planning Pregnancy: Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Prior Failed Medication: _____ | <input type="checkbox"/> Clinical Progress Notes, Relevant Labs with dates, etc. |
| <input type="checkbox"/> Number of Relapses in Past Year: _____ | |

- Last MRI Date: _____ Previously Treated for this Condition: Yes No Any MRI Changes: Yes No
- First Clinical Episode of MS: Yes No -If YES, are MRI features consistent with MS: Yes No
- Patient Weight: _____ Kg/Lbs Patient Height: _____ Inches/CM BSA: _____ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> GILENYA	<input type="checkbox"/> 0.5mg Capsule	<input type="checkbox"/> Take one capsule by mouth daily		
<input type="checkbox"/> GLATOPIA	<input type="checkbox"/> 20mg PFS	<input type="checkbox"/> Inject SQ once daily		
	<input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject SQ 3 times weekly at least 48 hours apart, on the same 3 days each week	28 Day	
<input type="checkbox"/> KESIMPTA	<input type="checkbox"/> 20mg/0.4ml PF Pen	<input type="checkbox"/> Induction- Inject 20mg SQ at weeks 0, 1, and 2	28 Day	
	<input type="checkbox"/> 20mg/0.4ml PF Syringe	<input type="checkbox"/> Maintenance- Inject 20mg SQ once monthly starting at week 4		
<input type="checkbox"/> MAYZENT	<input type="checkbox"/> 1mg Starter Pack	<input type="checkbox"/> Take as directed		
	<input type="checkbox"/> 2mg Starter Pack			
<input type="checkbox"/> PLEGRIDY	<input type="checkbox"/> 1mg	<input type="checkbox"/> Take one tablet by mouth once daily		
	<input type="checkbox"/> 2mg			
	<input type="checkbox"/> Starter Pack PFS (IM)	<input type="checkbox"/> Titration- Inject 63 mcg on day 1, 94mcg on day 15, and 125mcg on day 29		
	<input type="checkbox"/> Starter Pack Pen (SQ)	<input type="checkbox"/> Maintenance- Inject 125mcg every 14 days		
	<input type="checkbox"/> 125mcg PFS (IM)			
	<input type="checkbox"/> 125mcg Pen (SQ)			

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

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

**Multiple Sclerosis
Enrollment Form R-Z**

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



Date: _____

Patient Name: _____

Date of Birth: _____

DIAGNOSIS

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Relapsing Remitting | <input type="checkbox"/> Clinically Isolated Syndrome | <input type="checkbox"/> G35: _____ |
| <input type="checkbox"/> Primary Progressive | <input type="checkbox"/> Secondary Progressive | <input type="checkbox"/> Other: _____ |

PREVIOUS ADMINISTRATION

Is the patient currently on therapy? Yes No

If YES, please provide the following information:

Medication: _____
 Last Dose Date: _____
 Next Dose Date: _____
 Duration of Treatment: _____
 Reason for Discontinuing: _____ DC Date: _____
 Will Current Therapy be DC'd prior to starting new therapy: Yes No

If NO, please indicate desired location for delivery of first dose:

- Physician's Office
 Patient's Home
 Enroll in Manufacturer Nurse Training
 Desired Start Date: _____

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- (Please attach documents as needed)

- | | |
|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Patient Demographics and Insurance Information |
| <input type="checkbox"/> This Signed Order Form | <input type="checkbox"/> Pregnant, Nursing or Planning Pregnancy: Yes <u> </u> No <u> </u> |
| <input type="checkbox"/> Prior Failed Medication: _____ | <input type="checkbox"/> Clinical Progress Notes, Relevant Labs with dates, etc. |
| <input type="checkbox"/> Number of Relapses in Past Year: _____ | |

- Last MRI Date: _____ Previously Treated for this Condition: Yes No Any MRI Changes: Yes No
 First Clinical Episode of MS: Yes No -If YES, are MRI features consistent with MS: Yes No
 Patient Weight: _____ Kg/Lbs Patient Height: _____ Inches/CM BSA: _____ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<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"/> Titration: Inject SQ 3 times weekly- 4.4mcg weeks 1-2, 11mcg week 5 and thereafter (PFS Only) <input type="checkbox"/> Inject SQ 3 times weekly- 8.8mcg weeks 1-2, 22mcg weeks 3-4, 44 mcg week 5 and thereafter (PFS or Rebidose) <hr/> <input type="checkbox"/> Maintenance: Inject SQ 3 times weekly		
<input type="checkbox"/> TERIFLUNOMIDE	<input type="checkbox"/> 7mg <input type="checkbox"/> 14mg	<input type="checkbox"/> Take one tablet by mouth once daily		
<input type="checkbox"/> ZEPOSIA	<input type="checkbox"/> 7 Day Starter Pack <input type="checkbox"/> 37 Day Starter Kit <hr/> <input type="checkbox"/> 0.92mg Capsule	<input type="checkbox"/> Titration- Take 0.23mg by mouth daily on days 1-4, take 0.46mg daily on days 5-7, and 0.92mg daily thereafter <input type="checkbox"/> Maintenance- Take one capsule (0.92mg) by mouth daily		

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

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.