Multiple Sclerosis Enrollment Form A-E

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

DIAGNOSIS

☐ Relapsing Remitting ☐ Clinically Isolated Syndrome ☐ G35: _____

☐ Primary Progressive ☐ Secondary Progressive ☐ 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 proir 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)*

☐ History and Physical

☐ This Signed Order Form

☐ Prior Failed Medication: _____

☐ Number of Relapses in Past Year: _____

☐ Patient Demographics and Insurance Information

☐ Pregnant, Nursing or Planning Pregnancy: Yes ____ No ____

☐ Clinical Progress Notes, Relevant Labs with dates, etc.

☐ 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
☐ AVONEX	☐ Pen	☐ 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
	☐ Pre-filled Syringe	☐ Maintenance- Inject IM 30mcg weekly	28 Day	
☐ BETASERON	☐ 0.3mg Vial	☐ 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	
		☐ Inject 1ml SQ every other day	28 Day	
☐ COPAXONE	☐ 20mg PFS ☐ 40mg PFS	☐ Inject SQ once daily ☐ Inject SQ 3 times weekly at least 48 hours apart, on the same 3 days each week		
☐ DALFAMPRIDINE (Ampyra)	☐ 10mg Tablet	☐ Take one tablet by mouth twice daily 12 hours apart		
☐ DIMETHYLFUMARATE (Tecfidera)	☐ 30-day Starter Pack (14 x 120mg Capsules) (46 x 240mg Capsules) ☐ 14 x 120mg capsules ☐ 60 x 240mg capsules	☐ Titration- Take 120mg by mouth twice daily for 7 days, then take 240mg twice daily		0
		☐ Maintenance- Take one capsule (240mg) by mouth twice daily		
☐ EXTAVIA	☐ 0.3mg Vial	☐ 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
		☐ 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 aslo authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

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

Multiple Sclerosis Enrollment Form G-P

Date: _____

Patient Name: _____

Date of Birth: _____

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☐ Primary Progressive ☐ Secondary Progressive ☐ Other: _____

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Medication:

Last Dose Date: _____

Next Dose Date: _____

Duration of Treatment:

Reason for Discontinuing: _____ DC Date: _____

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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)*

☐ History and Physical

☐ This Signed Order Form

☐ Prior Failed Medication: _____

☐ Number of Relapses in Past Year: _____

☐ Patient Demographics and Insurance Information

☐ Pregnant, Nursing or Planning Pregnancy: Yes ____ No ____

☐ Clinical Progress Notes, Relevant Labs with dates, etc.

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

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

Multiple Sclerosis Enrollment Form R-Z

Date: _____

Patient Name: _____

Date of Birth: _____

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

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☐ This Signed Order Form

☐ Prior Failed Medication: _____

☐ Number of Relapses in Past Year: _____

☐ Patient Demographics and Insurance Information

☐ Pregnant, Nursing or Planning Pregnancy: Yes ____ No ____

☐ Clinical Progress Notes, Relevant Labs with dates, etc.

☐ 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
☐ REBIF	☐ PFS Titration Kit ☐ Rebidose Titration Kit ☐ PFS 22mcg ☐ PFS 44mcg ☐ Rebidose 22mcg ☐ Rebidose 44mcg	Titration: ☐ Inject SQ 3 times weekly- 4.4mcg weeks 1-2, 11mcg weeks 3-4, and 22mcg week 5 and thereafter (PFS Only) ☐ Inject SQ 3 times weekly- 8.8mcg weeks 1-2, 22mcg weeks 3-4, 44 mcg week 5 and thereafter (PFS or Rebidose) ☐ Maintenance: Inject SQ 3 times weekly		
☐ TERIFLUNOMIDE	☐ 7mg ☐ 14mg	☐ Take one tablet by mouth once daily		
☐ ZEPOSIA	☐ 7 Day Starter Pack ☐ 37 Day Starter Kit	☐ Titration- Take 0.23mg by mouth daily on days 1-4, take 0.46mg daily on days 5-7, and 0.92mg daily thereafter		
	☐ 0.92mg Capsule	☐ Maintance- Take one capsule (0.92mg) by mouth daily		

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