Multiple Sclerosis Enrollment Form

ENCOMPASS RX

Fax: 404-367-9199

Phone: 404-367-9111

Deliver Medications To: ☐ **Patient's Home** ☐ **Doctors Office** **Date Needed By:** _____ **Inj. Training/Admin. Y N**

Patient Demographics

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Prescription Insurance: (PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT"S CARD)

Primary Prescription Insurance: _____ RX BIN #: _____ RX PCN#: _____

Patient ID/Policy Number: _____ Patient RX Group Number: _____

Patient Clinical Information/History: (Please attach a copy of patient's recent chart notes, pathology, and labs)

☐ Multiple Sclerosis 340.0 ☐ Relapse-Remitting ☐ Progressive ☐ Other Height: _____ Weight: _____ Sex: M F

Drug Allergies: _____

Previous Drug Regimens (if any): _____

Patient Support and Injection Training Authorization

I authorize Encompass RX to enroll patient in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training and PRN administration by Nurse. Patient further authorizes Encompass to release and communicate to the corresponding manufacturer the minimum necessary information about thier health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, contact me occasionally for market research purposes, and provide educational information regarding therapies and disease states. I understand patient may revoke this authorization at anytime in writing by sending a letter to Encompass RX 500 Bishop St Ste A-3 Atlanta GA 30318.. I understand that patient may refuse authorization and that refusal will not affect patient ability to obtain treatment from the pharmacy.

Prescription Information

Drug	Strength	Directions	Quantity	Refill
☐ **Aubagio**	☐ 7 mg ☐ 14 mg	Take one tablet my mouth once a day	☐ 28 day supply (1 box) ☐ 84 day supply (3 boxes)	
☐ **Avonex**	☐ 30mcg PFS ☐ 30mcg Pen	Inject 30mcg intramuscularly once a week	☐ 4 week supply (1 kit) ☐ 12 week supply (3 kits)	
☐ **Betaseron** ☐ Include Betaject LITE Autojector	0.3mg	☐ Inject 0.25 mg sc every other day ☐ Dose Titration: Weeks 1-2 - Inject 0.25ml sc qod Weeks 3-4 - Inject 0.5ml sc qod Weeks 5-6 - Inject 0.75ml sc qod Weeks 7+ - Inject 1ml sc qod ☐ Other:	☐ 4 week supply (1 kit) ☐ 12 week supply (3 kits)	
☐ **Copaxone** ☐ Include Autoject	20mg PFS	Inject 20mg sc qd	☐ 4 week supply ☐ 12 week supply	
☐ **Extavia** ☐ Autojector II	0.3mg	☐ Inject 0.25 mg sc every other day ☐ Dose Titration: Weeks 1-2 - Inject 0.25ml sc qod Weeks 3-4 - Inject 0.5ml sc qod Weeks 5-6 - Inject 0.75ml sc qod Weeks 7+ - Inject 1ml sc qod	☐ 4 week supply ☐ 12 week supply	
☐ **Gilenya**	0.5mg	☐ Take one 0.5mg capsule po qd	☐ 4 week supply ☐ 12 week supply	
☐ **Rebif**	☐ Titration Pack	☐ Inject 8.8mcg sc 3 x a week for 2 weeks, then 22mcg sc 3 x a week for 2 weeks, then maintenance dose.		
	☐ 22mcg PFS	☐ Inject 22mcg sc 3 a week		
	☐ 44mcg PFS	☐ Inject 44mcg sc 3 a week		
☐ **Tecfidera (Also complete Pt. Start Form)**	☐ 120mg	120mg po BID for 7 days, then 240mg po BID	30 day Starter Pack	0
	☐ 240mg	240mg po BID	60 capsules	
☐ **Tysabri (Also complete Touch Form)**	300mg/ml 15ml SDV	300mg infusion over one hour every 4 weeks		
☐ **Ampyra (Also complete Ampyra Form)**	10mg	Take 10mg po BID		
☐ **Other**				

Prescriber Information:

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: **Office Fax:** **Office Contact:**

DEA: NPI: UPIN: State License:

Physician Signature: _____ **Date:** _____