Sunray Specialty Pharmacy

Multiple Sclerosis Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____
Alternate Phone: _____
DOB: _____
Last 4 Digits of SS#: _____
Gender: _____
Language Preference: _____

PRESCRIBER INFORMATION:

Prescriber's Name: _____
DEA: _____
NPI: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact Person's Phone: _____

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

☐ G35 Multiple Sclerosis
☐ Other Diagnosis: ICD-10 Code _____
Description: _____

Number of Relapses in Past Year: _____
Date of Diagnosis _____
Date of Last MRI _____
MRI Changes: ☐ Yes ☐ No

Additional information:

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Prior Treatment: ☐ Avonex® ☐ Copaxone® ☐ Rebif® ☐ Betaseron®
☐ Extavia ® ☐ Other _____
Treatment Response _____
Treatment Dates _____
Allergies: _____
Lab Data: _____
Concomitant Medications: _____
_____

Start Date _____ Review Date _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Avonex®	☐ 30 mcg Prefilled Syringe ☐ 30 mcg Pen ☐ 30 mcg Pack (4 vials)			
Betaseron®	☐ 0.3 mg Vial & Diluent			
Copaxone®	☐ 20 mg Syringe ☐ 40 mg Syringe			
Extavia®	☐ 0.3 mg Vial			
Gilenya®	☐ 0.5 mg Capsule			
Glatopa®	☐ 20 mg Syringe ☐ 40 mg Syringe			
Mitoxantrone®	☐ 20 mg/10 mL Vial ☐ 25 mg/12.5 mL Vial ☐ 30 mg/15 mL Vial			
Rebif®	☐ Titration Pack ☐ Rebidose® Auto-Injector Titration ☐ 22 mcg Syringe ☐ Rebidose® Auto-Injector 22 mcg ☐ 44 mcg Syringe ☐ Rebidose® Auto-Injector 44 mcg			
Tysabri®	☐ 300 mg Vial	*Complete manufacturer enrollment form*		
OTHER: _____				

Please deliver to: ☐ Patient ☐ Office ☐ Other _____ by this date: _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution Permitted ☐ Dispense as Written

Prescriber's Signature: _____