

# Multiple Sclerosis Enrollment Form



**Clinical Specialty Infusions, LLC**  
**Toll Free: 833-569-1005**  
**Pharmacy Fax: 430-200-4889**

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always
<b>Please fax a copy of the front and back of the insurance card(s).</b>	

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> G35 (Multiple Sclerosis) <input type="checkbox"/> _____		Diagnosis Date: _____	
Type: <input type="checkbox"/> Clinically isolated syndrome <input type="checkbox"/> Relapsing-remitting <input type="checkbox"/> Primary-progressive		<input type="checkbox"/> Secondary-progressive	
For Amypra® (dalfampridine): 25-foot timed walking test (T25-FW): _____ seconds/minutes; _____ seconds/minutes			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Self-Injectable	Quantity	Refill
<input type="checkbox"/> <b>Avonex®</b> (interferon beta-1a)	<input type="checkbox"/> Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	<input type="checkbox"/> 4 x 30 mcg PFS 0
	<input type="checkbox"/> Inject 30 mcg intramuscularly once weekly	<input type="checkbox"/> 4 x 30 mcg <input type="checkbox"/> Pens <input type="checkbox"/> PFS <input type="checkbox"/> Vials _____
<input type="checkbox"/> <b>Betaseron®</b> (interferon beta-1b)	<input type="checkbox"/> Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	<input type="checkbox"/> 14 x 0.3 mg Vials 0
	<input type="checkbox"/> Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	<input type="checkbox"/> 14 x 0.3 mg Vials 0
	<input type="checkbox"/> Inject 0.25 mg (1 mL) subcut every other day	<input type="checkbox"/> 14 x 0.3 mg Vials _____
<input type="checkbox"/> <b>Copaxone®</b> (glatiramer acetate)	<input type="checkbox"/> Inject 20 mg subcut once daily	<input type="checkbox"/> 30 x 20 mg PFS _____
	<input type="checkbox"/> Inject 40 mg subcut three times per week at least 48 hours apart	<input type="checkbox"/> 12 x 40 mg PFS _____
<input type="checkbox"/> <b>Extavia®</b> (interferon beta-1b)	<input type="checkbox"/> Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	<input type="checkbox"/> 15 x 0.3 mg Vials 0
	<input type="checkbox"/> Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-onward: Inject 0.25 mg (1 mL) subcut every other day.	<input type="checkbox"/> 15 x 0.3 mg Vials 0
	<input type="checkbox"/> Inject 0.25 mg (1 mL) subcut every other day	<input type="checkbox"/> 15 x 0.3 mg Vials _____
<input type="checkbox"/> <b>Kesimpta (ofatumumab)</b>	<input type="checkbox"/> Loading dose: Inject 20mg subcut at weeks 0, 1 and 2	<input type="checkbox"/> 3 x 20 mg PFS _____
	<input type="checkbox"/> Inject 20mg subcut starting in week 4 and give monthly thereafter	<input type="checkbox"/> 12 x 20 mg PFS _____
<input type="checkbox"/> <b>Glatopa™</b> (glatiramer acetate)	<input type="checkbox"/> Inject 20 mg subcut once daily	<input type="checkbox"/> 30 x 20 mg PFS _____
	<input type="checkbox"/> Inject 40 mg subcut three times per week at least 48 hours apart	<input type="checkbox"/> 12 x 40 mg PFS _____
<input type="checkbox"/> <b>Plegridy®</b> (peginterferon beta-1a)	<input type="checkbox"/> Inject 63 mcg subcut on day 1; then inject 94 mcg on day 15	<input type="checkbox"/> 1 x 63 mcg Pens PFS 0
	<input type="checkbox"/> Inject 125 mcg subcut on day 29 and every two weeks thereafter	<input type="checkbox"/> 2 x 125 mcg Pens PFS _____
<input type="checkbox"/> <b>Rebif®</b> (interferon beta-1a)	<input type="checkbox"/> Week 1-2: Inject 4.4 mcg (0.1 mL) subcut three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subcut three times per week.	<input type="checkbox"/> 6 x 8.8 mcg PFS 0 <input type="checkbox"/> 6 x 22 mcg
	<input type="checkbox"/> Week 5 and thereafter: Inject 22 mcg subcut three times per week	<input type="checkbox"/> 12 x 22 mcg <input type="checkbox"/> Autoinjectors <input type="checkbox"/> PFS _____
	<input type="checkbox"/> Week 1-2: Inject 8.8 mcg (0.2 mL) subcut three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subcut three times per week.	<input type="checkbox"/> 6 x 8.8 mcg <input type="checkbox"/> Autoinjectors <input type="checkbox"/> PFS 0 <input type="checkbox"/> 6 x 22 mcg
	<input type="checkbox"/> Week 5 and thereafter: Inject 22 mcg subcut three times per week	<input type="checkbox"/> 12 x 44 mcg <input type="checkbox"/> Autoinjectors <input type="checkbox"/> PFS _____

Specialty Support Therapy	Quantity	Refill
<input type="checkbox"/> <b>Ampyra®</b> (dalfampridine) <input type="checkbox"/> Take 10 mg by mouth twice a day, approximately 12 hours apart	<input type="checkbox"/> 60 x 10 mg tablets	_____

By signing this form and utilizing our services, you are authorizing CSI PHARMACY and its employees to serve as your prior authorization agent when dealing with medical and prescription insurance companies.

\*This is not a valid prescription

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