Neurology Enrollment Form

SKYEMED PHARMACY & INFUSION SERVICES

Phone: 866-778-8255
Fax: 800-432-6614
pharmacy@skyemed.com

Deliver Medications To: ☐ Patient's Home ☐ Doctors Office ☐ Skyemed to Train **Date Needed By:**_____

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: _____

Secondary Insurance: _____ ID: Bin: PCN: Phone:

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

Diagnosis: G35 Multiple Sclerosis Date of Diagnosis: _____ Height: _____ Weight (lbs): _____

☐ Relapsing/Remitting ☐ 1○ Progressive ☐ 2○ Progressive ☐ Clinically Definite MS

Is Patient Pregnant, Nursing or planning Pregnancy: Y N Sex: M F

Drug Allergies: _____ ☐ NKDA

Current medications including OTC: _____

Previous Therapies: _____

Prescription Information

Betaseron 03.mg ☐ Inj 0.25mg(1ml) SQ Every Other Day

☐ Dose Titration:
Weeks 1-2: Inj 0.0625mg/0.25ml SQ QOD
Weeks 3-4: Inj 0.125mg/0.5ml SQ QOD
Weeks 5-6: Inj 0.1875mg/0.75ml SQ QOD
Weeks 7+: Inj 0.25mg/1ml SQ QOD

☐ Other: _____

☐ BETAJECT Lite Autoinjector Use As Directed

Quantity: 4 doses Refills: _____

Avonex ☐ 30mcg Prefilled Syringe

☐ 30mcg Single Dose

☐ 30mcg Avonex Pen

☐ **Inject 30mcg IM once a week**

☐ **Other:** _____

Quantity: 4 doses Refills: _____

Extavia: 03.mg ☐ Inj 0.25mg(1ml) SQ Every Other Day

☐ Dose Titration:
Weeks 1-2: Inj 0.0625mg/0.25ml SQ QOD
Weeks 3-4: Inj 0.125mg/0.5ml SQ QOD
Weeks 5-6: Inj 0.1875mg/0.75ml SQ QOD
Weeks 7+: Inj 0.25mg/1ml SQ QOD

☐ Other: _____

☐ EXTAVIA Autoinjector II Use As Directed

Quantity: 4 doses Refills: _____

☐ **Copaxone** 20mg Prefilled Syringe
Inject 20mg SQ Daily

☐ Autoinject 2 for glass syringe device Use As Directed

Quantity: 30 Refills: _____

☐ **Gilenya 0.5mg**

Take 1 Capsule PO Once Daily

Quantity: _____ Refills: _____

Rebif ☐ Inj 44mcg SQ Three Times a Week

Dose Titration:
☐ Weeks 1-2: Inject 8.8mcg SQ TIW
Weeks 3-4: Inject 22mcg SQ TIW
Weeks 5+: Inject 44mcg SQ TIW
☐ Other: _____

Quantity: _____ Refills: _____

☐ **Novantrone 20mg/10ml MD Vial**

Dilute and Administer 12mg/m2 as IV infusion every 3 months. Max cumulative lifetime dose=140mg/m2

Quantity: _____ Refills: _____

☐ **IVIG** _____ **gms**

Infuse: ☐ QD ☐ QW ☐ MWF ☐ QM

Doses: _____ Infused Over _____

Premeds: _____

_____

Aubagio ☐ 7mg Tablet
☐ 14mg Tablet

Take 1 Tablet PO Once Daily

Quantity: _____ Refills: _____

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:** _____

***If Physician requests Brand Name Only, "Brand Medically Necessary" Must be handwritten below:**