MS **ENROLLMENT FORM**

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

GREENHILL PLUS
Specialty Pharmacy Solution
Connection • Care • Community
Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805 | Fax: 302-502-3885

Patient Information

Patient Name _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ SSN _____ Gender ○ M ○ F
Weight _____ kg/lbs Height _____ cm/in
Language Preference: ○ English ○ Spanish ○ Other _____
Caregiver Name _____ Relation _____
Local Pharmacy _____ Phone _____
Insurance Plan _____ Plan ID _____
Please fax a copy of front and back of the insurance card(s)

Prescriber Information & Shipping Information

Prescriber's Name _____
NPI _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Contact _____
Phone _____ Alternate Phone _____
Fax _____
Email _____
If shipping to prescriber ○ First Fill ○ Always ○ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ○ G35 (Multiple Sclerosis) ○ _____ Diagnosis Date: _____
Type: ○ Clinically isolated syndrome ○ Relapsing-remitting ○ Secondary-progressive ○ Primary-progressive ○ Progressive-relapsing
Hepatic Impairment Present: ○ Yes ○ No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dl Lab Date: _____
Pre-existing hepatic conditions: ○ HBV ○ HCV ○ _____ TB Test: ○ Positive ○ Negative Test Date: _____
Prior Therapy ○ Yes ○ No Reason for Discontinuation of Therapy Approximate Start Date Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ○ NKDA ○ Other: _____

Prescription Information

Drugs	Direction	Quantity	Refills
Ampyra®	To order Ampyra® please see the Acorda form at ampyra-hcp.com/local/files/acorda-service-request-form.pdf Phone: 888-881-1918 Fax: 888-883-3053		
Aubagio® (teriflunomide)	○ Take 7 mg by mouth once daily	○ 28x7 mg tablets	
	○ Take 14 mg by mouth once daily	○ 28x14 mg tablets	
Avonex® (interferon beta-1a) ○PFS ○Pens ○Vials	○ 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	○ 4x30 mcg	
	○ Inject 30 mcg intramuscularly once weekly	○ 4x30 mcg	
Betaseron® (interferon beta-1b) ○Vials	○ 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.	○ 14x0.3 mg	
	○ 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.	○ 14x0.3 mg	
	○ Inject 0.25 mg (1 ml) subcut every other day	○ 14x0.3 mg	
Copaxone® (glatiramer acetate) ○PFS	○ Inject 20 mg subcut once daily	○ 30x20 mg	
	○ Inject 40 mg subcut three times per week at least 48 hours apart	○ 12x40 mg	
Extavia® (interferon beta-1b) ○Vials	○ 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.	○ 15x0.3 mg	
	○ 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.	○ 15x0.3 mg	
	○ Inject 0.25 mg (1 ml) subcut every other day	○ 15x0.3 mg	

Drugs	Direction	Quantity	Refills
Gilenya® (fingolimod)	○ Take 0.5 mg by mouth once daily	○ 30x0.5 mg capsules	
Glatopa™ (glatiramer acetate) ○PFS	○ Inject 20 mg subcut once daily	○ 30x20 mg	
Plegridy® (peginterferon beta-1a) ○Pens ○PFS	○ Inject 63 mcg subcut on day 1; then inject 94 mcg on day 15	○ 1x63 mcg ○ 1x94 mcg	
	○ Inject 125 mcg subcut on day 29 and every two weeks thereafter	○ 2x125 mcg	
Rebif® (interferon beta-1a) □Autoinjectors PFS	○ 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.	○ 6x8.8 mcg ○ 6x22 mcg	
	○ Week 5 and thereafter: Inject 22 mcg subcut three times per week	○ 12x22 mcg	
	○ 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.	○ 6x8.8 mcg ○ 6x22 mcg	
	○ Week 5 and thereafter: Inject 44 mcg subcut three times per week	○ 12x44 mcg	
Tecfidera® (dimethyl fumarate)	○ Take 120 mg by mouth twice daily for 7 days, then 240 mg by mouth twice daily thereafter.	○ 30-day starter pack	
	○ Take 240 mg by mouth twice daily	○ 60x240 mg capsules	
	○ _____	○ _____	
Zinbryta™ (daclizumab)	To order, please see the Zinbryta™ forms at https://www.zinbrytarems.com/		

Injection Training Provided by: ○Physician's Office ○Pharmacy ○Other: _____
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Ship to: ○ ***Patient*** ○ ***Office*** ○ ***Other*** _____ ***Date*** _____ ***Needs by 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.

Prescriber's Signature: _____ _____ ***Date:*** _____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: _____