Dolphin Health Rx
Committed to Helping People Get Well

Multiple Sclerosis Enrollment Form
Injectable Medications

Toll Free: 844-436-5744
Local Phone: 510-900-3131
Fax: 844-329-6979

1 PATIENT INFORMATION

Written Date:

Ship To:
- ☐ Patient (All Fills)
- ☐ Provider (1st Fill Only)
- ☐ Provider (All Fills)
- ☐ _____

Patient Name:
Date of Birth:
SSN:
Address:
City, State, Zip Code:
Phone:
Email Address:
Preferred language:
Contact Person:

2 INSURANCE INFORMATION

PLEASE FAX A COPY (FRONT AND BACK) OF PATIENT'S CURRENT ACTIVE INSURANCE AND ID CARDS. FOR PATIENTS WITH BOTH MEDICARE AND MEDI-CAL, PLEASE FAX IN COPIES FOR BOTH.

3 SPECIAL INSTRUCTION

Training:
- ☐ Pharmacy will coordinate training for patient
- ☐ Provider will provide training
- ☐ Training not necessary
- ☐ Enroll patient In manufacturer support program

Delivery: _____

4 CLINICAL INFORMATION

PLEASE FAX COPIES OF RECENT CHART NOTES, LABS, EVIDENCE OF DIAGNOSIS, AND CURRENT MEDICATION LIST.

5 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-9 or ICD-10)

Date of Diagnosis _____

☐ G35 Multiple Sclerosis ☐ Other ICD-10 Code and Description _____

Has patient had positive TB test? ☐ YES ☐ NO If yes, date of last chest x-ray: _____

Height: _____ Weight: _____ Allergies: _____

Is the patient currently on therapy? ☐ YES ☐ NO If YES, what medication and when did they start? _____

Number of relapses in the past year _____

Date of last MRI _____ MRI changes ☐ YES ☐ NO

Previously Tried/Failed Medications- include dosage and frequency	Date of Trial	Reason for Discontinuation

6 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Avonex® IFN beta-1a**	☐ AVOSTARTGRIP® titration kit	☐ Dose titration: 7.5mcg (1/4 dose) IM week 1; 15mcg (1/2 dose) IM week 2; 22.5mcg (3/4 dose) IM week 3; 30mcg (full dose) every week thereafter	☐ 1 kit	0 (not refillable)
	☐ 30mcg single dose vial ☐ 30mcg single dose prefilled syringe ☐ 30mcg autoinjector pen (single dose)	☐ Inject 30mcg IM one time per week.	☐ 4-week supply (1 kit) ☐ 12- week supply (3 kits	
☐ Rebif® (prefilled syringes) or	☐ Titration Pack (6x8.8mcg & 6x22mcg prefilled syringes). **Use only syringes for titration to 22mcg target dose.**	☐ Dose titration: • Weeks 1-2: Inject 4.4mcg (half of 8.8mcg syringe) SQ3x week; • Weeks 3-4: 11mcg (half of 22 mcg syringe) SQ 3x week; • Weeks 5+: 22 mcg SQ 3x week	☐ 1-Syringe Titration Pack (28 day supply)	0 (not refillable)
☐ Rebif Redidose® (autoinjector) IFN beta-1a	☐ Titration Pack (6x8.8mcg & 6x22mcg prefilled syringes or autoinjector) for 44mcg target dose.	☐ Dose titration: • Weeks 1-2: Inject 8.8mcg SQ 3 x week; • Weeks 3-4: 22mcg SQ 3X week; • Weeks 5+: 44 mcg SQ 3x week;	☐ 1-Syringe Autoinjector Titration Pack (28 day supply)	0 (not refillable)
	☐ 22mcg prefilled syringe or autoinjector ☐ 44mcg prefilled syringe or autoinjector	☐ Maintenance: Inject 22mcg SQ 3 times a week ☐ Maintenance: Inject 44mcg SQ 3 times a week ☐ Other _____	☐ 4-week supply (1 kit) ☐ 12-week supply (3 kits) ☐ Other _____	
☐ Plegridy® PEG IFN beta-1a	☐ Starter Pack (1x63mcg pen & 1x94mcg pen) ☐ Prefilled syringe starter pack (1x63mcg prefilled syringe & 1x94mcg prefilled syringe)	☐ Dose titration: · Day 1 admin 63mcg/0.5mL SQ; · Day 15 admin 94mcg/0.5mL SQ; · Starting Day 29 admin 125mcg/0.5mL SQ every 14 days	☐ Starter Pack 28-day supply	0 (not refillable)
	☐ Maintenance Pack (2x125mcg pens) ☐ Prefilled syringe maintenance pack (2x125mcg prefilled syringes)	☐ Inject 125mcg/0.5mL SQ every 14 days ☐ Other _____	☐ Maintenance Pack 84-day supply ☐ Maintenance Pack 28-day supply	
☐ Betaseron® IFN beta-1b OR ☐ Extavia® IFN beta-1b	0.3 mg	☐ Dose titration: · Weeks 1-2: Inject 0.0625mg/0.25mL SQ QOD · Weeks 3-4: Inject 0.125mg/0.5mL SQ QOD · Weeks 5-6: Inject 0.1875mg/0.75mL SQ QOD · Weeks 7+: Inject 0.25mg/1mL SQ QOD ☐ Maintenance: Inject 0.25mg (1mL) SQ QOD. ☐ Other _____	☐ 28-day supply (1 kit of 14 vials) ☐ 84-day supply (3 kits of 14 vials)	
☐ Copaxone® glatiramer acetate	☐ 20mg Prefilled Syringe	Inject 20mg SQ QD	☐ 30 syringes (1kit) ☐ 90 syringes (3kits)	
	☐ 40mg Prefilled Syringe	Inject 40mg SQ 3x week (@ least 48 hours apart)	☐ 12 syringes (1kit) ☐ 36 syringes(3 kits)	
☐ Glatopa® glatiramer acetate	20mg/mL Prefilled Syringe	Inject 20mg SQ QD	☐ 30 syringes (1kit) ☐ 90 syringes (3kits)	
☐ Zinbryta® daclizumab	150mg/mL Prefilled Syringe	Inject 150mg SQ one time per month	☐ 1 syringe ☐ 3 syringes	

7 PROVIDER AUTHORIZATION & INFORMATION

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and To execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Name: _____ Address: _____

DEA: _____ NPI: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____

Page 1 Continue...

Date: _____ Provider Signature: _____ ☐ Do not substitute