Multiple Sclerosis Enrollment Form A-E

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

DIAGNOSIS

- ☐ Relapsing Remitting
- ☐ Primary Progressive
- ☐ Clinically Isolated Syndrome
- ☐ Secondary Progressive
- ☐ G35: _____
- ☐ Other: _____

PREVIOUS ADMINISTRATION

Is the patient currently on therapy? _____ Yes _____ No

If YES, please provide the following information:

Medication:

Last Dose Date: _____

Next Dose Date: _____

Duration of Treatment:

Reason for Discontinuing: _____ DC Date: _____

Will Current Therapy be DC'd proir to starting new therapy: Yes ____ No ____

If NO, please indicate desired location for delivery of first dose:

- ☐ Physician's Office
- ☐ Patient's Home
- ☐ Enroll in Manufacturer Nurse Training

Desired Start Date: _____

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- *(Please attach documents as needed)*

- ☐ History and Physical
- ☐ This Signed Order Form
- ☐ Prior Failed Medication: _____
- ☐ Number of Relapses in Past Year: _____
- ☐ Patient Demographics and Insurance Information
- ☐ Pregnant, Nursing or Planning Pregnancy: Yes ____ No ____
- ☐ Clinical Progress Notes, Relevant Labs with dates, etc.

☐ Last MRI Date: _____ ☐ Previously Treated for this Condition: Yes ____ No ____ ☐ Any MRI Changes: Yes ____ No ____

☐ First Clinical Episode of MS: Yes ____ No ____ -If YES, are MRI features consistent with MS: Yes ____ No ____

☐ Patient Weight: _____ Kg/Lbs ☐ Patient Height: _____ Inches/CM ☐ BSA: _____ ☐ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **AVONEX**	☐ Pen	☐ Titration- (PFS only and requires Avostartgrip kit) Inject IM 7.5mcg week 1,15mcg week 2, 22.5mcg week 3, and 30mcg weekly thereafter	28 Day	0
	☐ Pre-filled Syringe	☐ Maintenance- Inject IM 30mcg weekly	28 Day	
☐ **BETASERON**	☐ 0.3mg Vial	☐ Titration- Inject 0.25ml SQ every other day for weeks 1-2, 0.5ml weeks 3-4, 0.75ml weeks 5-6, and 1ml week 7 and thereafter	56 Day	
		☐ Inject 1ml SQ every other day	28 Day	
☐ **COPAXONE**	☐ 20mg PFS ☐ 40mg PFS	☐ Inject SQ once daily ☐ Inject SQ 3 times weekly at least 48 hours apart, on the same 3 days each week		
☐ **DALFAMPRIDINE (Ampyra)**	☐ 10mg Tablet	☐ Take one tablet by mouth twice daily 12 hours apart		
☐ **DIMETHYLFUMARATE (Tecfidera)**	☐ 30-day Starter Pack (14 x 120mg Capsules) (46 x 240mg Capsules) ☐ 14 x 120mg capsules ☐ 60 x 240mg capsules	☐ Titration- Take 120mg by mouth twice daily for 7 days, then take 240mg twice daily		0
		☐ Maintenance- Take one capsule (240mg) by mouth twice daily		
☐ **EXTAVIA**	☐ 0.3mg Vial	☐ Titration- Inject 0.25ml SQ every other day for weeks 1-2, 0.5ml weeks 3-4, 0.75ml weeks 5-6, and 1ml week 7 and thereafter	56 Day	0
		☐ Inject 1ml SQ every other day	28 Day	

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

V 09.03.24

Please See Infusion Forms for Briumvi, Lemtrada and Tyasbri

Multiple Sclerosis Enrollment Form G-P

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

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DIAGNOSIS

- ☐ Relapsing Remitting
- ☐ Clinically Isolated Syndrome
- ☐ G35: _____
- ☐ Primary Progressive
- ☐ Secondary Progressive
- ☐ Other: _____

PREVIOUS ADMINISTRATION

Is the patient currently on therapy? _____Yes _____ No

If YES, please provide the following information:

Medication:

Last Dose Date: _____

Next Dose Date: _____

Duration of Treatment:

Reason for Discontinuing: _____ DC Date: _____

Will Current Therapy be DC'd proir to starting new therapy: Yes ____ No ____

If NO, please indicate desired location for delivery of first dose:

- ☐ Physician's Office
- ☐ Patient's Home
- ☐ Enroll in Manufacturer Nurse Training

Desired Start Date: _____

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- *(Please attach documents as needed)*

- ☐ History and Physical
- ☐ This Signed Order Form
- ☐ Prior Failed Medication: _____
- ☐ Number of Relapses in Past Year: _____
- ☐ Patient Demographics and Insurance Information
- ☐ Pregnant, Nursing or Planning Pregnancy: Yes ____ No ____
- ☐ Clinical Progress Notes, Relevant Labs with dates, etc.

☐ Last MRI Date: _____ ☐ Previously Treated for this Condition: Yes ____ No ____ ☐ Any MRI Changes: Yes ____ No ____

☐ First Clinical Episode of MS: Yes ____ No ____ -If YES, are MRI features consistent with MS: Yes ____ No ____

☐ Patient Weight: _____ Kg/Lbs ☐ Patient Height: _____ Inches/CM ☐ BSA: _____ ☐ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **GILENYA**	☐ 0.5mg Capsule	☐ Take one capsule by mouth daily		
☐ **GLATOPA**	☐ 20mg PFS	☐ Inject SQ once daily		
	☐ 40mg PFS	☐ Inject SQ 3 times weekly at least 48 hours apart, on the same 3 days each week	28 Day	
☐ **KESIMPTA**	☐ 20mg/0.4ml PF Pen ☐ 20mg/0.4ml PF Syringe	☐ Induction- Inject 20mg SQ at weeks 0, 1, and 2 ☐ Maintenance- Inject 20mg SQ once monthly starting at week 4	28 Day	
☐ **MAYZENT**	☐ 1mg Starter Pack ☐ 2mg Starter Pack	☐ Take as directed		
	☐ 1mg ☐ 2mg	☐ Take one tablet by mouth once daily		
☐ **PLEGRIDY**	☐ Starter Pack PFS (IM) ☐ Starter Pack Pen (SQ)	☐ Titration- Inject 63 mcg on day 1, 94mcg on day 15, and 125mcg on day 29		
	☐ 125mcg PFS (IM) ☐ 125mcg Pen (SQ)	☐ Maintenance- Inject 125mcg every 14 days		

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V 09.03.24

Please See Infusion Forms for Briumvi, Lemtrada and Tyasbri

Multiple Sclerosis Enrollment Form R-Z

Date: _____

Patient Name: _____

Date of Birth: _____

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DIAGNOSIS

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Desired Start Date: _____

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- *(Please attach documents as needed)*

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- ☐ This Signed Order Form
- ☐ Prior Failed Medication: _____
- ☐ Number of Relapses in Past Year: _____
- ☐ Patient Demographics and Insurance Information
- ☐ Pregnant, Nursing or Planning Pregnancy: Yes ____ No ____
- ☐ Clinical Progress Notes, Relevant Labs with dates, etc.

☐ Last MRI Date: _____ ☐ Previously Treated for this Condition: Yes ____ No ____ ☐ Any MRI Changes: Yes ____ No ____

☐ First Clinical Episode of MS: Yes ____ No ____ -If YES, are MRI features consistent with MS: Yes ____ No ____

☐ Patient Weight: _____ Kg/Lbs ☐ Patient Height: _____ Inches/CM ☐ BSA: _____ ☐ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **REBIF**	☐ PFS Titration Kit ☐ Rebidose Titration Kit ☐ PFS 22mcg ☐ PFS 44mcg ☐ Rebidose 22mcg ☐ Rebidose 44mcg	Titration: ☐ Inject SQ 3 times weekly- 4.4mcg weeks 1-2, 11mcg weeks 3-4, and 22mcg week 5 and thereafter (PFS Only) ☐ Inject SQ 3 times weekly- 8.8mcg weeks 1-2, 22mcg weeks 3-4, 44 mcg week 5 and thereafter (PFS or Rebidose) ☐ Maintenance: Inject SQ 3 times weekly		
☐ **TERIFLUNOMIDE**	☐ 7mg ☐ 14mg	☐ Take one tablet by mouth once daily		
☐ **ZEPOSIA**	☐ 7 Day Starter Pack ☐ 37 Day Starter Kit	☐ Titration- Take 0.23mg by mouth daily on days 1-4, take 0.46mg daily on days 5-7, and 0.92mg daily thereafter		
	☐ 0.92mg Capsule	☐ Maintance- Take one capsule (0.92mg) by mouth daily		

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