Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

AccuSERV® PHARMACY

Clear Form

Multiple Sclerosis Enrollment Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821 Single Point of Contact: (724) 515-7053

1. Patient Information

Start Date:_____ Ship to: ☐ Patient ☐ Office _____ Other

Patient Name:_____ ○M ○F DOB:_____ Weight:_____

Address: _____ SSN: _____

Phone:_____ Alt Phone:_____ Caregiver:_____

Allergies: _____ Comorbidities: _____

2. Clinical Information: *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:_____ Prior Therapy:_____

Reason for Discontinuation: _____

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Avonex®	○ 30 mcg/0.5 mL Kit	○ Wk 1: Inject 7.5 mcg (0.125mL) IM once every week Wk 2: Inject 15 mcg (0.25mL) IM once every week Wk 3: Inject 22.5 mcg (0.375mL) IM once every week Wk 4: Inject 30 mcg (0.5mL) IM once every week ○ Inject 30 mcg intramuscularly once every week	○ 4 PFS ○ 4 Pens ○ 4 Vials ○	
	Betaseron®	○ 0.3 mg	○ Wk 1-2: Inject 0.0625 mg (0.25mL) Sub-Q every other day Wk 3-4: Inject 0.125 mg (0.5mL) Sub-Q every other day ○ Wk 5-6: Inject 0.1875 mg (0.75mL) Sub-Q every other day Wk 7-8: Inject 0.25 mg (1mL) Sub-Q every other day ○ Inject 0.25 mg (1mL) Sub-Q every other day	○ 14 PFS ○ 14 Vials ○	
	Copaxone®	○ 20 mg (30ct) ○ 40 mg (12ct)	○ Inject 20 mg Sub-Q once a day ○ Inject 40 mg Sub-Q 3 times per week, 48 hrs apart, on the same 3 days each week	○ 30 PFS _____ PFS	
	Extavia®	○ 0.3 mg	○ Wk 1-2: Inject 0.0625 mg (0.25mL) Sub-Q every other day Wk 3-4: Inject 0.125 mg (0.5mL) Sub-Q every other day ○ Wk 5-6: Inject 0.1875 mg (0.75mL) Sub-Q every other day Wk 7-Future: Inject 0.25 mg (1mL) Sub-Q every other day ○ Inject 0.25 mg (1mL) Sub-Q every other day	○ 15 Vials	
	Gilenya®	○ 0.5 mg	○ Take 1 capsule daily	○ 30 Capsules	
	Glatopa®	○ 20 mg/ 1mL	○ Inject 20 mg Sub-Q once a day ○ Inject 40 mg Sub-Q 3 times per week, 48 hrs apart, on the same 3 days each week	○ 30 PFS _____ PFS	
	Rebif®	○ 8.8 mcg (6ct) 22mcg (6ct) ○ 22 mcg (12ct) ○ 44mcg (12ct)	○ Wk 1-2: Inject 4.4 mcg (0.1mL) Sub-Q 3 times per week Wk 3-4: Inject 11 mcg (0.25mL) Sub-Q 3 times per week ○ Wk 5-Future: Inject 22 mcg (0.5mL) Sub-Q 3 times per week ○ Wk 1-2: Inject 8.8 mcg (0.2mL) Sub-Q 3 times per week Wk 3-4: Inject 22 mcg (0.5mL) Sub-Q 3 times per week ○ Wk 5-Future: Inject 44 mcg (1mL) Sub-Q 3 times per week	○ Autoinjector ○ PFS	

4. Prescriber and Shipping Information

Prefered Method of Contact: ○ phone ○ fax ○ email

Prescriber (print) : _____ Office Contact: _____

Contact email:_____ Phone: _____

Office Address:_____

Fax:_____ NPI:_____ DEA#:_____

Prescriber Signature:_____ Date: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information **Please fax a copy of insurance card front and back. Enlarge if possible.**

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.