ardon

**Multiple Sclerosis Enrollment Form**
Phone: 855-425-4085
Fax: 855-425-4096
ardonhealth.com

**PATIENT INFORMATION**

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email: _____
Last Four of SS #: _____ Primary Language: _____
Height: _____ Weight: _____

**PRESCRIBER INFORMATION**

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

**INSURANCE INFORMATION:** PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

**CLINICAL**

| | |
|---|---|
| **Need By Date:** | **Ship to:** ☐ Patient ☐ Physician ☐ Other: |
| **Date of Diagnosis:** ☐ Relapsing Remitting ☐ Primary Progressive ☐ Progressive – Relapsing ☐ Secondary Progressive with Relapses<br>**Diagnosis:** G35 Multiple Sclerosis ☐ Secondary Progressive w/o Relapses ☐ Other (ICD-10 Code): | Number of Relapses Last Year: |
| **Previously Failed Medications:** | |
| **Current Medications:** | |
| **Allergies:** | **Is the patient new to therapy?** ☐ **Yes** ☐ **No** |

**PRESCRIPTION INFORMATION**

| MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ Avonex PFS<br>☐ Avonex SDV<br>☐ Avonex Pen | ☐ 30mcg | ☐ **Titration Dosing (SDV or PFS):** Week 1: Inject 7.5mcg IM.<br>Week 2: Inject 15mcg IM.<br>Week 3: Inject 22.5mcg.<br>Week 4: Start injecting 30mcg once a week.<br>☐ Inject 30mcg IM once a week. | ☐ 4 PFS<br>☐ 4 SDV<br>☐ 4 Pens | |
| ☐ Betaseron | ☐ 0.3mg | ☐ **Titration Dosing:** Weeks 1–2: Inject 0.0625mg (0.25ml) SQ QOD.<br>Weeks 3–4: Inject 0.125mg (0.5ml) SQ QOD.<br>Weeks 5–6: Inject 0.1875mg (0.75ml) SQ QOD.<br>Week 7: Start injecting 0.25mg (1ml) SQ QOD.<br>☐ Inject 0.25mg (1ml) every other day. | ☐ 14 Vials | |
| ☐ Copaxone PFS<br>☐ Glatopa PFS | ☐ 20mg<br>☐ 40mg | ☐ Inject 20mg SQ daily.<br>☐ Inject 40mg SQ 3 times a week.<br>☐ Other | ☐ 30<br>☐ 12 | |
| ☐ Extavia | ☐ 0.3mg | ☐ **Titration Dosing:** Weeks 1–2: Inject 0.0625mg (0.25ml) SQ QOD.<br>Weeks 3–4: Inject 0.125mg (0.5ml) SQ QOD.<br>Weeks 5–6: Inject 0.1875mg (0.75ml) SQ QOD.<br>Week 7: Start injecting 0.25mg (1ml) SQ QOD.<br>☐ Inject 0.25mg (1ml) every other day. | ☐ 15 Vials | |
| ☐ Gilenya | ☐ 0.5mg Cap | ☐ Take 1 cap PO daily. | ☐ 30 | |
| ☐ Rebif Titration Pack<br>☐ Rebif Rebidose Titration Pack | ☐ Titration Pack<br>☐ 22mcg<br>☐ 44mcg | ☐ **Titration to 22mcg dose:** Weeks 1–2: Inject 4.4mcg SQ 3 times a week.<br>Weeks 3-4: Inject 11mcg SQ 3 times a week.<br>Week 5: Start injecting 22mcg SQ 3 times a week.<br>☐ **Titration to 44mcg dose:** Weeks 1-2: Inject 8.8mcg SQ 3 times a week.<br>Weeks 3-4: Inject 22mcg SQ 3 times a week.<br>Week 5: Start injecting 44mcg SQ 3 times a week. | ☐ 1 Titration Kit = six 8.8mcg+ six 22mcg Syringes | |
| ☐ Rebif PFS<br>☐ Rebif Rebidose Autoinjector | ☐ 22mcg<br>☐ 44mcg | ☐ Inject 22mcg SQ 3 times a week.<br>☐ Inject 44mcg SQ 3 times a week.<br>☐ Other | ☐ 12 | |
| ☐ Aubagio | ☐ 7mg Tab<br>☐ 14mg Tab | ☐ Take 1 tab PO daily. | ☐ 28 | |

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)
Ancillary supplies and kits provided as needed for administration.

X _____
DISPENSE AS WRITTEN (Date)

PHYSICIAN SIGNATURE REQUIRED

Date Needed: _____ Medication Start Date: _____