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ENROLLMENT FORM

Today's Date:___________
Needed By:_____________

Last update 12.04.2018

www.commcarepharmacy.com
Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_______________________________
Address:_______________________________
City, State, Zip:_______________________________
Preferred Phone:_______________ Alt. Phone:_______________
Last four digits of SS#:_____________ Date of Birth:_______________
Gender:__ Allergies:_______________Height:__________ Weight:________

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_______________ Group/Hospital: _______________
Specialty:_______________ License#:_______________Tax ID#:________
Address:_______________________________
NPI:_______________________ DEA:_______________
City, State, Zip:_______________________________
Phone:__________ Fax:____________ Office Contact:_______________

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: ☐G35 Multiple Sclerosis Severity: ☐Severe ☐Moderate Type: ☐Relapsing/Remitting ☐Primary Progressive ☐Secondary Progressive ☐Other: _______________

Injection Training:☐Patient has received injection training ☐Physician's office to provide injection training ☐Commcare Specialty Pharmacy to coordinate injection training

Requested Clinical Information: *Please send/attach clinical notes*

Previous Therapies: ____

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐**Avonex®**	☐30mcg Autoinjector Pen ☐30mcg Prefilled Syringe ☐30mcg Vial	☐Inject 30mcg IM Once A Week ☐Other: ______________________	☐28 Day Supply ☐Other: _______________	
☐**Betaseron®**	☐0.3mg Vial ☐*Betaconnect™ Autoinjector*	☐**Titration Dose** • Inject (0.25mL) 0.0625mg SQ Every Other Day (Week 1 - 2) • Inject (0.5mL) 0.125mg SQ Every Other Day (Week 3 - 4) • Inject (0.75mL) 0.1875mg SQ Every Other Day (Week 5 - 6) • Inject (1mL) 0.25mg SQ Every Other Day (Week 7+) ☐**Maintenance Dose**: Inject (1ml) 0.25mg SQ Every Other Day	☐28 Day Supply (14 Vials) ☐Other: _______________	
☐**Copaxone®** Generics: ☐**Glatiramer** ☐**Glatopa**	☐20mg Prefilled Syringe ☐40mg Prefilled Syringe ☐*Copaxone Autoject® 2 glass syringe Injection Device*	☐Inject 20mg SQ Daily ☐Inject 40mg SQ Three Times A Week ☐Other: ______________________	☐30 Day Supply (30 Syringes) ☐28 Day Supply (12 Syringes) ☐Other: _______________	
☐**Extavia®**	☐0.3mg Vial	☐**Titration Dose** • Inject (0.25mL) 0.0625mg SQ Every Other Day (Week 1 - 2) • Inject (0.5mL) 0.125mg SQ Every Other Day (Week 3 - 4) • Inject (0.75mL) 0.1875mg SQ Every Other Day (Week 5 - 6) • Inject (1mL) 0.25mg SQ Every Other Day (Week 7+) ☐**Maintenance Dose**: Inject (1ml) 0.25mg SQ Every Other Day	☐30 Day Supply (15 Vials) ☐Other: _______________	
☐**Gilenya®**	☐0.5mg Capsule ☐0.25mg Capsule *(pediatric)*	☐Take 0.5mg PO Daily ☐Take 0.25mg PO Daily *(pediatric)* **(Must ship first fill to MD's office)*	☐30 Day Supply ☐Other: _______________	
☐**Rebif®**	☐Titration Pack – Rebidose® Pen Autoinjector ☐Titration Pack – Pre-filled Syringes ☐22mcg Rebidose® Pen Autoinjector ☐44mcg Rebidose® Pen Autoinjector ☐22mcg Prefilled Syringe ☐44mcg Prefilled Syringe	☐**Titration Dose** — (*only intended if maintenance dose 44 mcg)* • Inject 8.8mcg SQ Three Times A Week (Week 1 - 2) • Inject 22mcg SQ Three Times A Week (Week 3 - 4) • Inject 44mcg SQ Three Times A Week (Week 5+) ☐**Maintenance Dose**: Inject 22mcg SQ Three Times a Week ☐**Maintenance Dose**: Inject 44mcg SQ Three Times a Week	☐Titration Pack (no refills) ☐28 Day Supply ☐Other: _______________	
☐**Tecfidera®**	☐30-day Starter Pack ☐120mg Capsule ☐240mg Capsule	☐**Initial:** Take 120mg PO BID for 7 days then 240mg PO BID ☐**Maintenance Dose**: Take 240mg PO Twice Daily ☐Other: ______________________	☐Titration Pack (no refills) ☐30 Day Supply ☐Other: _______________	
☐**Plegridy®**	☐Starter Pack – Pen Auto-Injector ☐Starter Pack – Prefilled Syringe ☐125mcg/0.5mL Pen Auto-Injector ☐125mcg/0.5mL Prefilled Syringe	☐**Initial:** Inject 63mcg SQ once on day 1, 94mcg on day 15, and then 125mcg on day 29 ☐**Maintenance Dose**: Inject 125mcg SQ every 14 days ☐Other: ______________________	☐Titration Pack (no refills) ☐30 Day Supply ☐Other: _______________	
☐**Other**			**SQ = subcutaneously**	

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_______________________________ ☐DAW (Dispense as Written) **Date:**_______________

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)______________________________ Date:_______________ □ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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