

**McKESSON**

Empowering Healthcare

McKesson Specialty Pharmaceutical  
700 Waterfront Dr.  
Pittsburgh, PA 15222**PRESBYTERIAN****MULTIPLE SCLEROSIS THERAPY  
ENROLLMENT FORM****FAX TO: 1-800-724-6953 or 505-923-5540** Customer Service Phone: 1-888-923-5757  
**DATE NEEDED: \_\_\_\_\_ (MM / DD / YY)****PATIENT INFORMATION:**

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: M F
Patient Address:	City:	State:	Zip:	Primary Language:
Daytime Phone:	Evening Phone:	Best time to contact:		

**INSURANCE INFORMATION:**

Insured's Name:	Insured's SSN:	Insured's Employer (if known):
Insurance Name:	Insurance Address:	
Insurance Phone #:	ID # on Insurance Card:	Group #:
Name of Specific Plan:	Prior Authorization:	Valid Through:

**DIAGNOSIS INFORMATION:**

340 Multiple Sclerosis	Relapsing-Remitting	Primary-Progressive	Secondary-Progressive	Progressive-Relapsing
Other: _____				

**MEDICAL ASSESSMENT:**

Date MS Diagnosed:	Other Medications currently taking:
Allergies:	Pertinent Medical History:

**INJECTION TRAINING:**

Injection training will be / has been conducted by the physician's office? Yes No Date: _____
First Dose of medication will be / has been administered at physician's office? Yes No Date: _____ McKesson to coordinate / refer injection training? Yes No

**PRESCRIPTION INFORMATION:**

Medication	Manufacturer/Marketer sponsored patient support programs	Quantity	Refills
<b>Avonex</b> <sup>®</sup> 30 mcg IM QW with ancillary Supplies	Enroll in <i>MS Active Source</i> <sup>®</sup>	28-day supply	
<b>Betaseron</b> <sup>®</sup> 0.25 mg SQ QOD with ancillary supplies	Enroll in <i>MS Pathways</i> <sup>sm</sup>	30-day supply	
<b>Copaxone</b> <sup>®</sup> 20 mg SQ QD Autoject 2 refill PRN	Enroll in <i>Shared Solutions</i> <sup>®</sup>	30-day supply	
<b>Novantrone</b> <sup>®</sup> Dose: _____ with ancillary supplies Body Surface Area: _____ Recommended Dose: 12 mg/ m 2 IV infusion Q 3 months			
<b>Rebif</b> <sup>®</sup> 8.8 mcg SQ TIW-wks. 1-2 ; 22mcg SQ TIW-wks. 3-4 ; 44mcg SQ TIW-wks. 5+ 44 mcg SQ TIW Alt. Dosing: _____	Enroll in <i>MS Lifelines</i> <sup>TM</sup> – for <i>Rebject</i> <sup>®</sup> delivery		
Other ancillary supplies (Sharps container included):			
Other RX:	Physician Signature: _____		

**SHIPPING INFORMATION:**

Ship To: Physician's Office Other Address:
Patient's Home

**PHYSICIAN INFORMATION: (IF PHYSICIAN'S SHIPPING & BILLING ADDRESSES ARE DIFFERENT, PLEASE ATTACH ON A SEPARATE SHEET.)**

Physician Name:	Specialty:	Contact Name
Physician Address:	Phone #:	Secure Fax #:
Physician UPIN #:	Physician's DEA #:	License #:

Refrigerated prescriptions are shipped Mon. – Fri. via standard overnight service. Non-refrigerated prescriptions are shipped Mon. – Thurs. via 2-day delivery. Saturday delivery requires approval from a McKesson pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize McKesson to use and disclose my personal health information for the purposes of providing and facilitating treatment, claim payment related to my treatment, or conducting healthcare operations. This authorization includes McKesson's disclosure of my information to (i) establish my eligibility for benefits; (ii) provide me with products, supplies, or services; (iii) receive the payment for benefits on my behalf; (iv) communicate to other healthcare providers regarding the medical care provided or to be provided to me; (v) facilitate the provision of products, supplies, or services by a third party; and (vi) facilitate my registration in any applicable program recommended for my treatment. Unless otherwise required by law, this authorization will be effective until I revoke it in writing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

McK-19-051203