

MULTIPLE SCLEROSIS REFERRAL FORM

Updated October 2020

Patient Name _____ Today's Date _____ NEW Patient CURRENT Patient
 DOB _____ Height _____ Weight _____ Male Female Preferred Language _____
 Best Phone _____ Email _____
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Ship to Patient at: Home Physician Office Work Address _____
 Allergies _____
 Current Medications including OTC's (please fax a complete list) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
 Relation to Patient _____
Primary Insurance _____
 ID# _____ Group # _____
Secondary Insurance _____
 ID# _____ Group # _____

Ordering Prescriber _____

Office Contact _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____
 Email _____
 License# _____
 NPI# _____

ICD-10 Code G35 Multiple Sclerosis Date of Diagnosis: _____ Date of 1st demyelinating event: _____
 Yes No Previously Treated for this condition? Medications Failed _____
 Yes No Is Patient currently on therapy? Type/Medication(s) _____
 Yes No Will Patient stop taking the medication(s) before starting new medication?
 If yes, how long should Patient wait before starting new medication? _____
 Date of next blood work _____
 Type: Relapsing-Remitting Primary Progressive Clinically Isolated Syndrome (CIS)
 Progressive-relapsing Secondary progressive with relapses Secondary progressive without relapses

PRESCRIPTION

AVONEX ADMINISTRATION PACK 30 mcg PFS Single Dose Vial Single Dose Avonex Pen
 SIG: Inject 30 mcg IM once weekly QTY: # _____ Weeks (1 pack = 4 week supply) Refill: _____
 Other _____ QTY: # _____ Weeks (1 pack = 4 week supply) Refill: _____

BETASERON 0.3mg Vials
 SIG: Inject _____ subcutaneously every other day QTY: # _____ Weeks (1 box = 4 week supply) Refill: _____
 Other _____ QTY: # _____ Weeks (1 box = 4 week supply) Refill: _____

COPAXONE (Glatiramer Acetate)
 40 mg/ml Syringe SIG: Inject 40 mg subcutaneously 3 times weekly QTY: # _____ Syringes Refill: _____
 Other _____ QTY: # _____ Syringes Refill: _____
 20 mg/ml Syringe SIG: Inject 20 mg subcutaneously once daily QTY: # _____ Syringes Refill: _____
 Other _____ QTY: # _____ Syringes Refill: _____

EXTAVIA VIALS SIG: Inject _____ subcutaneously every other day QTY: # _____ Weeks (1 box = 4 week supply) Refill: _____
 Other _____ QTY: # _____ Weeks (1 box = 4 week supply) Refill: _____

GILENYA 0.5 mg capsule SIG: Take one capsule by mouth once daily QTY: 28 Refill: _____

KESIMPTA 20 mg/0.4 mL Single-dose prefilled Sensoready Pen Single-dose PFS Hep B virus (HBV) & quantitative serum immunoglobulins screening are required before the first dose.
 SIG: Initial Dose: Inject 20 mg subcutaneously at weeks 0, 1, & 2 QTY: 3 Refill: _____
 Maintenance Dose: Inject 20 mg subcutaneously monthly starting at week 4 QTY: # _____ Weeks Refill: _____

REBIF TITRATION PACK Prefilled Syringes Rebidoze Prefilled Pens
 SIG: Inject 8.8 mcg subcutaneously TIW - weeks 1 & 2
 Inject 22 mcg subcutaneously TIW - weeks 3 & 4 Maintenance Dose following week 3 & 4
 QTY: # _____ Boxes (1 box = 4 week supply) Refill: _____

REBIF 22 mcg/0.5ml (48hrs apart) Prefilled Syringes Rebidoze Prefilled Pens
 SIG: Inject 22 mg (0.5ml) subcutaneously TIW QTY: # _____ Boxes (1 box = 4 week supply) Refill: _____

REBIF 44 mcg/0.5ml (maintenance) (48hrs apart) Prefilled Syringes Rebidoze Prefilled Pens
 SIG: Starting week 5: 44 mcg (0.5ml) subcutaneously TIW QTY: # _____ Boxes (1 box = 4 week supply) Refill: _____
 OTHER _____ QTY: # _____ Boxes (1 box = 4 week supply) Refill: _____

TECFIDERA Starter Pack 240mg tablet
 SIG: Starter Dose: Take 120mg by mouth twice daily for 7 days, then 240mg by mouth twice daily QTY: 1 Starter Pack Refills: 0
 SIG: Maintenance Dose: Take 240mg by mouth twice daily QTY: _____ Refill: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.