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** ☐ **Rebidose 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** ☐ **Rebidose 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** ☐ **Rebidose 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.

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