Multiple Scleriosis Referral Form

Date: _____

Evolutionary Pharmacy Solutions

Fax Referral To: 1-800-239-0363
Phone: 1-844-800-5377

EPSRX

PATIENT INFORMATION:	PRESCRIBER INFORMATION:
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Cell Phone: _____	Phone: _____
Home Phone: _____ Language: _____	Fax: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female	DEA: _____ NPI: _____
Guardian/Caregiver & Number: _____	Office Contact: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card if available)

Insurance Name: _____	Insurance Name: _____
Contact Number: _____	Contact Number: _____
Cardholder Name: _____ DOB: _____	Cardholder: _____ DOB: _____
ID Number: _____	ID Number: _____ PCN: _____
Group Number: _____	Group Number: _____ BIN: _____

CLINICAL INFORMATION

DIAGNOSIS: Multiple Sclerosis ICD-10 G35

Date of Diagnosis: _____

TYPE:

- ☐ Relapsing – Remitting
- ☐ Primary Progressive
- ☐ Secondary Progressive
- ☐ Progressive Relapsing
- ☐ Other Diagnosis: _____

Weight (kg): _____ SCr _____ **Therapy** ☐ New ☐ Reauthorization ☐ Restart

# of Relapses: _____ Date of last MRI: _____ MRI changes: ☐ Yes ☐ No

Prior Treatment: ☐ Avonex ☐ Copaxone ☐ Rebif ☐ Betaseron ☐ Other: _____

Tx Response/Dates: _____

Patient Pregnant, Nursing or Planning on being pregnant: ☐ Yes ☐ No ☐ N/A

Concomitant Medications: _____

Allergies: _____

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Ampyra** (Acorda)	☐ 10mg tablet			
☐ **Aubagio** (Genzyme)	☐ 7mg tablet ☐ 14mg tablet			
☐ **Avonex** (Biogen Idec) ☐ Enroll in MS ActiveSource	☐ 30mcg syringe ☐ 30mcg pen			
☐ **Betaseron** (Bayer) ☐ Enroll in BETAPLUS	☐ 0.3mg vial & diluent			
☐ **Copaxone** (Teva) ☐ Enroll in Shared Solutions	☐ 20mg syringe ☐ 40mg syringe			
☐ **Extavia** (Novartis) ☐ Enroll in MS Inspirations	☐ 0.3mg vial & diluent			
☐ **Gienya** (Novartis) ☐ Enroll in Gilenya GoProgram	☐ 0.5mg capsule			
☐ **Glatopa** (Sandoz) ☐ Enroll in GlatopaCare	☐ 20mcg syringe			
☐ **Novantrone** (EMD Serono) ☐ Enroll in MS LifeLines	☐ 10mg/5ml vial ☐ 20mg/10ml vial			
☐ **Ocrevus** (Genentech) ☐ Enroll in Ocrevus Access Soln	☐ 300mg/10ml single dose vial ☐ Nursing services requested			
☐ **Rebif** (EMD Serono) ☐ Enroll in MS LifeLines	☐ Titration Pack ☐ Rebidose starter ☐ 22mcg syringe ☐ Rebidose 22mcg/0.5ml ☐ 44mcg syringe ☐ Rebidose 44mcg/0.5ml			
☐ **Tecfidera** (Biogen) ☐ Enroll in MS ActiveSource	☐ 120mg capsule ☐ 240mg capsule ☐ 30 day starter pack			
☐ **Tysabri** : Contact TOUCH (P) 1-800-456-2255 (F) 1-800-840-1278 ☐ **Lemtrada:** Contact MS One-to-One (P) 1-855-676-6326				

Ship to: ☐ Patient ☐ Office ☐ Other: _____ Date: _____ Need by Date: _____

Patient Support Programs: Please sign & date to enroll in pharmaceutical company assisted patient support program: **Patient Signature:** _____ **Date:** _____

☐ Product substitution permitted ☐ Dispense as written

PRESCRIBER SIGNATURE: _____ **DATE:** _____

Verbal Readback ☐ Yes ☐ No

***Stamp signature not allowed, physician signature required ***