Multiple Sclerosis Referral Form

Date:__________________________

Evolutionary Pharmacy Solutions

Fax Referral To: 1-800-239-0363

Phone: 1-844-800-5377

PATIENT INFORMATION:

Patient Name: ______________________________________
Address: ______________________________________
City, State, Zip: ______________________________________
Cell Phone: ______________________________________
Home Phone: __________________ Language:________________
Date of Birth: __________________ Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: ____________________________

PRESCRIBER INFORMATION:

Prescriber Name: ______________________________________
Address: ______________________________________
City, State, Zip: ______________________________________
Phone: ______________________________________
Fax: ______________________________________
DEA:____________________ NPI: ____________________
Office Contact: ______________________________________

INSURANCE INFORMATION

Attach a copy of the Front and Back of the Insurance and Prescription Card. Prior Authorization Reference Number:________________________

CLINICAL INFORMATION

DIAGNOSIS: Multiple Sclerosis ICD-10 G35

Date of Diagnosis: ____________________

TYPE: ☐ Relapsing – Remitting
☐ Secondary Progressive
☐ Progressive Relapsing
☐ Primary Progressive
☐ Other Diagnosis: ____________

Therapy: ☐ New ☐ Reauthorization ☐ Restart Injection Training Needed: ☐ Yes ☐ No

\# of Relapses this year: ________ Date of last MRI: ____________ MRI changes: ☐ Yes ☐ No

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

Weight (kg): __________ Pregnant, Nursing or Planning on being pregnant:☐ Yes ☐ No ☐ N/A

SCr ______ TB/PPD Test Given? ☐ Yes ☐ No Negative TB Test & Date: ______________

☐ Attach Medication List ☐Allergies:______________________________________

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Avonex** (interferon beta-1a) ☐ Enroll in Above MS (1-800-456-2255)	☐ 30mcg/0.5ml syringe ☐ 30mcg/0.5ml pen	☐ Inject 30mcg IM once weekly ☐ Other: ________________________	☐ 1 month supply	
☐ **Betaseron** (interferon beta-1b) ☐ BetaConnect Autoinjector ☐ Enroll in BETAPLUS (1-844-788-1470)	☐ 0.3mg vial & diluent	☐ Initial Dosing Titration: Week 1-2: 62.5mcg/0.25ml SQ every other day Week 3-4: 125mcg/0.50ml SQ every other day Week 5-6: 187.5mcg/0.75ml SQ every other day Week 7: 250mcg/1 ml SQ every other day ☐ Maintenance Dose: 250mcg/ml SQ every other day	☐ 1 month supply	
☐ **Copaxone** (glatiramer acetate) ☐ **Glatopa** (glatiramer acetate) ☐ **Glatiramer Acetate** ☐ Enroll in Copaxone Shared Soln ☐ Enroll in GlatopaCare ☐ Enroll in Advocate Program	☐ 20mg syringe ☐ 20mg **Glatopa** syringe ☐ 40mg syringe (1-800-887-8100) (1-855-452-8672) (1-844-695-2667)	☐ Inject 20mg subcutaneously daily ☐ Inject 40mg subcutaneously three times a week (at least 48 hours apart)	☐ 1 month supply	
☐ **Extavia** (interferon beta-1b) ☐ Enroll in Extavia Go Program (1-866-398-2842)	☐ 0.3mg vial & diluent	☐ Initial Dosing Titration: Week 1-2: 62.5mcg/0.25ml SQ every other day Week 3-4: 125mcg/0.50ml SQ every other day Week 5-6: 187.5mcg/0.75ml SQ every other day Week 7: 250mcg/1 ml SQ every other day ☐ Maintenance Dose: 250mcg/ml SQ every other day	☐ 1 month supply	
☐ **Gilenya** (fingolimod) ☐ Enroll in Gilenya GoProgram (1-800-445-3692)	☐ 0.5mg capsule (>40kg) ☐ 0.25mg capsule (< 40kg)	☐ Take 1 capsule by mouth every day	☐ 1 month supply	
☐ **Mayz**ent (siponimod) ☐ Enroll in Alongside MS (1-877-629-9368)	☐ 0.25mg tablets ☐ 2mg tablets ☐ Starter Pack (titration to 2mg)	☐ Day 1-2: Take 0.25mg QD, Day 3: Take 0.50mg QD, Day 4: Take 0.75mg QD, Day 5: Take 1mg QD ☐ Dose Titration to 2mg with starter pack Maintenance: ☐ Take 1mg PO QD ☐ Take 2mg PO QD	☐ 1 month supply	
☐ **Ocrevus** (ocrelizumab) ☐ Enroll in Ocrevus Access Soln (1-877-436-3683)	☐ 300mg/10ml single dose vial ☐ Nursing services requested	☐ Infuse 300mg IV on day 1 then 300mg IV 2 weeks later ☐ 6 months after 1st dose: Infuse 600mg IV every 6 months		
☐ **Rebif** (interferon beta-1a) ☐ Enroll in MS LifeLines (1-877-447-3243)	☐ Titration Pack ☐ Rebidose starter ☐ 22mcg syringe ☐ Rebidose 22mcg/0.5ml ☐ 44mcg syringe ☐ Rebidose 44mcg/0.5ml ☐ Rebiject autoinjector (from MS Lifelines)	☐ Inject 8.8mcg SQ 3 times weekly for 1-2 weeks & Inject 22mcg SQ 3 times weekly for 3-4 weeks ☐ Inject 44mcg SQ TIW ☐ Inject 22mcg SQ TIW ☐ Other: ________________________	☐ 1 month supply	

Ship to: ☐ Patient ☐ Office ☐ Other: ______________________ Date: ______________ Need by Date: ________________

☐ Product substitution permitted ☐ Dispense as written ☐ Enrollment into pharmaceutical company assisted patient support program

PRESCRIBER SIGNATURE: ____ DATE:______________

Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required ***

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