

Date: _____

Multiple Sclerosis Referral Form

PATIENT INFORMATION:

PRESCRIBER INFORMATION:

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Cell Phone: _____
 Home Phone: _____ Language: _____
 Date of Birth: _____ Gender: Male Female
 Guardian/Caregiver & Number: _____

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

Ship to: Patient Office Other: _____ 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 *