

Neurology & Multiple Sclerosis Referral Form

PATIENT INFORMATION

Patients Name:		SSN#:		DOB:	
Address:		City:		State:	
Home Phone:		Cell Phone:		Height:	
				Weight:	
Email Address:				Gender: Male Female	
				Diagnosis Code:	

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

PRIOR TREATMENT HISTORY

Avonex® Betaseron® Copaxone® Glatopa™ Extavia® Gilenya® Rebif® Other _____

NEUROLOGY MEDICATIONS

Tetrabenazine 12.5mg 25mg

Sig/Directions:

Gilenya® - Enroll in Gilenya GoProgram

0.5mg by Mouth Once a Day

Rebif® - Enroll in MS LifeLines®

Prefilled Syringe/Rebject II® Rebif Rebidose®

Titration Pack:

Goal Dose 22 mcg: (Full Dose Therapy Beginning Week 5) 4.4 mcg/0.1 mL SubQ Three Times Weekly Week 1-211mcg/0.25mL SubQ Three Times Weekly Weeks 3-4

Goal Dose 44 mcg: (Full Dose Therapy Beginning Week 5) 8.8 mcg/0.1 mL SubQ Three Times Weekly Week 1-222mcg/0.25mL Three Times Weekly Weeks 3-4

Maintenance Dosing:

44mcg 22mcg SubQ Three Times Per Week

Rebject* (*Will come from MS Lifelines®)

Other

Strength:

Sig/Directions:

Quantity:

Refills:

MS MEDICATIONS

Avonex® - Enroll in Above MS

30 mcg (Prefilled Syringe Pen Vial) inject IM once weekly

Betaseron® - Enroll in BETAPLUS®

Starting Titration: 62.5mcg SubQ Every Other Day Weeks 1-2

Maintenance Dosing: 250mcg (1mL) SubQ Every Other Day

BetaConnect™

Copaxone® - Enroll in Shared Solutions®

(Glatiramer Acetate)

20mg SubQ Every Day 40mg SubQ Three Times Per Week

If want brand, please write "Brand Medically Necessary"

Glatopa™ - Enroll in GlatopaCare™

20mg SubQ Every Day

Extavia® - Extavia Go Program®

Starting Titration: 62.5mcg SubQ Every Other Day Weeks 1-2

Maintenance Dosing: 250mcg (1mL) SubQ Every Other Day

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact/Faxed by:		Email:			
NPI#:		TAX ID#:		Deliver To: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient Home	
Prescriber Signature					
<input type="checkbox"/> Dispense as written		Date			

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.