BlueCross BlueShield of Montana
Live Smart. Live Healthy.®

PRIME THERAPEUTICS
SPECIALTY PHARMACY™

SIGN AND FAX THIS FORM TO 877.828.3939
If you have questions, please call 877.627.MEDS (6337)

MULTIPLE SCLEROSIS REFERRAL FORM

PATIENT/PRESCRIBER

PATIENT INFORMATION		PRESCRIBER INFORMATION	
First name: MI:		Title: First name:	
Last name:		Last name:	State license #:
Patient DOB:	Sex:	Provider NPI #:	DEA #:
Address:		Office name:	Office contact:
City/State/Zip:		Address:	
Primary phone:		City/State/Zip:	
Alternate phone:		Phone:	Fax:

PLAN

FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS

Primary insurance:		Policy ID #:	Group #:
Policyholder name:		Policyholder DOB:	PCN: BIN:

CLINICAL

Primary diagnosis:	Date:	Height:	Weight:
ICD 9:	Date of diagnosis:	Allergies:	

Diagnosis: ☐ RRMS ☐ SPMS ☐ PPMS ☐ PRMS

Current therapy: ☐ Avonex ☐ Betaseron ☐ Copaxone ☐ Extavia ☐ Gilenya ☐ Novantrone ☐ Rebif ☐ Tysabri	Other therapies tried and failed (please list):
Other health conditions:	Current medications:

PRESCRIPTION INFORMATION

Date needed: ☐ New prescription ☐ Refill prescription ☐ New to therapy ☐ Restarting therapy

Deliver to: ☐ Patient's home ☐ Prescriber's facility ☐ Other:_____

MEDICATION	STRENGTH	QTY	DOSE, DIRECTIONS AND FREQUENCY
Avonex (interferon beta-la)	☐ 30 mcg prefilled syringes ☐ 30 mcg lyo vial kit		
Betaseron (interferon beta-lb)	☐ 0.3 mg syringe kit		
Copaxone (glatiramar acetate)	☐ 20 mg prefilled syringes		
Extavia (interferon beta-lb)	☐ 0.3 mg syringe kit		
Gilenya (fingolimod)	☐ 0.5 mg capsules		
Novantrone (mitoxantrone)	☐ 10 mg / 5 ml ☐ 20 mg / 10 ml ☐ Other		
Rebif (interferon beta-la)	☐ Titration kit ☐ 22 mcg prefilled syringes ☐ 44 mcg prefilled syringes		
Tysabri - contact TOUCH (Biogen Idec) 1-800-456-2255 or 1-800-840-1278 (Fax)			
☐ **Other:**			
SYMPTOM MANAGEMENT MEDICATIONS			
Ampyra (dalfampridine)	☐ 10 mg extended release tablet		
Lioresal IT (baclofen)			

☐ Check here if you would like associated supplies dispensed along with injectable medications. **REFILLS: NR 1 2 3 4 5** ____
State restrictions apply. Separate prescriptions are required in some jurisdictions.

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

☐ **Dispense as written/Do not substitute** **Date**

☐ **Substitution permitted/Brand exchange permitted** **Date**

For states requiring hand written expressions of product selection use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).

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