

**SIGN AND FAX THIS FORM TO 877.828.3939**

**If you have questions, please call 877.627.MEDS (6337)**

# MULTIPLE SCLEROSIS REFERRAL FORM

<b>PATIENT/PRESCRIBER</b>	<b>PATIENT INFORMATION</b>		<b>PRESCRIBER INFORMATION</b>	
	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:	

<b>PLAN</b>	<b>FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS</b>			
	Primary insurance:	Policy ID #:	Group #:	
	Policyholder name:	Policyholder DOB:	PCN:	BIN:

<b>CLINICAL</b>	Primary diagnosis:	Date:	Height:	Weight:
	ICD 9:	Date of diagnosis:	Allergies:	
	Diagnosis: <input type="checkbox"/> RRMS <input type="checkbox"/> SPMS <input type="checkbox"/> PPMS <input type="checkbox"/> PRMS			
	Current therapy: <input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron <input type="checkbox"/> Copaxone <input type="checkbox"/> Extavia <input type="checkbox"/> Gilenya <input type="checkbox"/> Novantrone <input type="checkbox"/> Rebif <input type="checkbox"/> Tysabri		Other therapies tried and failed (please list):	
Other health conditions:		Current medications:		

<b>PRESCRIPTION INFORMATION</b>	Date needed:	<input type="checkbox"/> New prescription	<input type="checkbox"/> Refill prescription	<input type="checkbox"/> New to therapy	<input type="checkbox"/> Restarting therapy
	Deliver to:	<input type="checkbox"/> Patient's home	<input type="checkbox"/> Prescriber's facility	<input type="checkbox"/> Other: _____	
	<b>MEDICATION</b>	<b>STRENGTH</b>	<b>QTY</b>	<b>DOSE, DIRECTIONS AND FREQUENCY</b>	
	Avonex (interferon beta-1a)	<input type="checkbox"/> 30 mcg prefilled syringes <input type="checkbox"/> 30 mcg lyo vial kit			
	Betaseron (interferon beta-1b)	<input type="checkbox"/> 0.3 mg syringe kit			
	Copaxone (glatiramar acetate)	<input type="checkbox"/> 20 mg prefilled syringes			
	Extavia (interferon beta-1b)	<input type="checkbox"/> 0.3 mg syringe kit			
	Gilenya (fingolimod)	<input type="checkbox"/> 0.5 mg capsules			
	Novantrone (mitoxantrone)	<input type="checkbox"/> 10 mg / 5 ml <input type="checkbox"/> 20 mg / 10 ml <input type="checkbox"/> Other			
	Rebif (interferon beta-1a)	<input type="checkbox"/> Titration kit <input type="checkbox"/> 22 mcg prefilled syringes <input type="checkbox"/> 44 mcg prefilled syringes			
Tysabri - contact TOUCH (Biogen Idec) 1-800-456-2255 or 1-800-840-1278 (Fax)					
<input type="checkbox"/> Other: _____					
<b>SYMPTOM MANAGEMENT MEDICATIONS</b>					
Ampyra (dalfampridine)	<input type="checkbox"/> 10 mg extended release tablet				
Lioresal IT (baclofen)					
<input type="checkbox"/> Check here if you would like associated supplies dispensed along with injectable medications. <b>REFILLS: NR 1 2 3 4 5</b> _____					
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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