MULTIPLE SCLEROSIS REFERRAL FORM (A-K)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

ICD-10 Code ☐ G35 Multiple Sclerosis ☐ Other:	Date of Diagnosis or Years with Condition			
Type of MS ☐ Relapsing ☐ Progressive Relapsing ☐ Primary Progressive ☐ Secondary Progressive ☐ Clinically Isolate Syndrome	Date of Last Relapse (if applicable):			
☐ New to Therapy ☐ Therapy Restart ☐ Existing Treatment	Expected Therapy Start Date/Date Med Needed			
Allergies ☐ NKDA ☐ Yes (please list)	☐ Other Allergies (please list)			
Past Meds Tried/Failed (please list)				
Other/Concomitant Medications (please list)				
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Ship to Address ☐ Home ☐ Prescriber's Address ☐ Other (please list)				

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Avonex®	☐ 30 mcg PFS ☐ 30 mcg Autoinjector	☐ Maintenance Dose: Inject 30 mcg (0.5 mL) IM every 7 days.	28-Day (1 Box)	
☐ Betaseron®	☐ 0.3 mg KIT (14 Vials)	☐ Dose Titration: • Weeks 1&2: Inject 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: Inject 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: Inject 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: Inject 0.25 mg (1 mL) SubQ every other day	1 Box	1
		☐ Maintenance Dose: Inject 0.25 mg (1 mL) SubQ every other day	28-day	
☐ Copaxone®	☐ 20 mg PFS	☐ Inject 20 mg SubQ once daily	30-day	
	☐ 40 mg PFS	☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-day	
☐ Dalfampridine ER	☐ 10 mg Tablet	☐ Take 10 mg by mouth twice daily, approximately 12 hours apart.	30-day	
☐ Extavia®	☐ 0.3 mg KIT (15 Vials)	☐ Dose Titration: • Weeks 1&2: Inject 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: Inject 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: Inject 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: Inject 0.25 mg (1 mL) SubQ every other day	1 Box	1
		☐ Maintenance Dose: Inject 0.25 mg (1 mL) SubQ every other day	30-day	
☐ Gilenya® **indicate First Dose Observation (FDO) status*	☐ 0.5 mg capsule	☐ Take 0.5 mg by mouth once daily. ☐ Continuation of therapy; FDO completed ☐ FDO planned – Date: _____	30-day	
☐ Glatiramer Acetate	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg SubQ once daily	30-Day	
		☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-Day	
☐ Glatopa	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg SubQ once daily	30-Day	
		☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-Day	
☐ Kesimpta *HBV & quantitative serum Ig screening required before 1st dose*	☐ 20 mg Autoinjector	☐ Loading Dose: Inject 20 mg (0.4 mL) SubQ at Weeks 0, 1 and 2.	3 Units	0
		☐ Maintenance Dose: Inject 20 mg (0.4 mL) SubQ monthly starting at week 4.	1 Unit	

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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MULTIPLE SCLEROSIS REFERRAL FORM (L-R)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

ICD-10 Code ☐ G35 Multiple Sclerosis ☐ Other:	Date of Diagnosis or Years with Condition			
Type of MS ☐ Relapsing ☐ Progressive Relapsing ☐ Primary Progressive ☐ Secondary Progressive ☐ Clinically Isolate Syndrome	Date of Last Relapse (if applicable):			
☐ New to Therapy ☐ Therapy Restart ☐ Existing Treatment	Expected Therapy Start Date/Date Med Needed			
Allergies ☐ NKDA ☐ Yes (please list)	☐ Other Allergies (please list)			
Past Meds Tried/Failed (please list)				
Other/Concomitant Medications (please list)				
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Ship to Address ☐ Home ☐ Prescriber's Address ☐ Other (please list)				

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Mayzent *1 mg daily dosing*	☐ 0.25 mg tablets	☐ Dose Titration to 1 mg: • Day 1&2: Take 0.25 mg PO once daily • Day 3: Take 0.50 mg PO once daily • Day 4: Take 0.75 mg PO once daily • Day 5+: Take 1 mg PO once daily	12 Tablets	0
		☐ Maintenance Dose: Take 1 mg PO once daily	28-Day	
☐ Mayzent *2 mg daily dosing*	☐ 2 mg tablets	☐ Dose Titration to 2 mg: Reference www.mayzenthcp.com for the "Start Form: or call 877.629.9368 for the starter pack		
		☐ Maintenance Dose: Take 2 mg PO once daily.	30-Day	
☐ Ocrevus™	☐ 300 mg/10 mL SDV	☐ Initial Dose: Infuse 300 mg IV on Day 1, followed by a second 300 mg IV infusion two weeks later	2 Vials (6 Months)	0
		☐ Maintenance Dose: Infuse 600 mg IV once every six months (begin 6 months after the first 300 mg dose)	2 Vials (6 Months)	
☐ Plegridy® *Starter Pack*	☐ PFS ☐ Autoinjector	☐ IM Initial Dose: Inject 63mcg IM on day 1 then inject 94mcg IM on day 15 ☐ SubQ Initial Dose: Inject 63mcg SubQ on day 1 then inject 94mcg SubQ on day 15	28-day	
☐ Plegridy® *Maintenance Dose*	☐ 125 mcg (PFS) ☐ 125 mcg (Autoinjector)	☐ IM Maintenance Dose: Inject 125mcg (0.5ml) IM every 14 days ☐ SubQ Maintenance Dose: Inject 125mcg (0.5ml) SubQ every 14 days	28-Day	
☐ Rebif® *Titration Pack* *Initial Dosing*	☐ PFS ☐ Rebidose Autoinjector Titration Packs Contain: 6x8.8 mcg devices 6x22mcg devices	☐ Loading Dose (22 mcg target dose) (PFS Only): • Weeks 1&2: Inject 4.4 mcg SubQ three times weekly • Weeks 3&4: Inject 11 mcg SubQ three times weekly • Weeks 5+: Inject 22 mcg SubQ three times weekly Separate doses by at least 48 hours.	1 Pack (28-Day)	0
		☐ Loading Dose (44 mcg target dose): • Weeks 1&2: Inject 8.8 mcg SubQ three times weekly • Weeks 3&4: Inject 22 mcg SubQ three times weekly • Weeks 5+: Inject 44 mcg SubQ three times weekly Separate doses by at least 48 hours.	1 Pack (28-Day)	0
☐ Rebif *Maintenance Dosing*	☐ 22 mcg Autoinjector ☐ 22 mcg PFS	☐ Maintenance Dose: Inject 22 mcg (0.5 mL) SubQ three times weekly. Separate doses by at least 48 hours.	28-day	
	☐ 44 mcg Autoinjector ☐ 44 mcg PFS	☐ Maintenance Dose: Inject 44 mcg (0.5 mL) SubQ three times weekly. Separate doses by at least 48 hours.	28-day	

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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REV.0222

MULTIPLE SCLEROSIS REFERRAL FORM (S-Z)

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AMBER™ SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City		State	ZIP
Email	Home Phone		Work Phone		Cell Phone
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)		Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email		Office Phone	Office Fax	
Practice / Facility Name		Prescriber Name / Specialty		
Address		City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

ICD-10 Code ☐ G35 Multiple Sclerosis ☐ Other:			Date of Diagnosis or Years with Condition	
Type of MS ☐ Relapsing ☐ Progressive Relapsing ☐ Primary Progressive ☐ Secondary Progressive ☐ Clinically Isolate Syndrome			Date of Last Relapse (if applicable):	
☐ New to Therapy ☐ Therapy Restart ☐ Existing Treatment		Expected Therapy Start Date/Date Med Needed		
Allergies ☐ NKDA ☐ Yes (please list)		☐ Other Allergies (please list)		
Past Meds Tried/Failed (please list)				
Other/Concomitant Medications (please list)				
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Ship to Address ☐ Home ☐ Prescriber's Address ☐ Other (please list)				

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Tecfidera®	☐ Titration / Starter Pack 14 x 120 mg capsules 46 x 240 mg capsules	☐ Initial Dose: Take 120 mg by mouth twice daily for seven days. Then, take 240 mg by mouth twice daily.	30-day	
	☐ 240 mg capsule ☐ 120 mg capsule	☐ Maintenance Dose: Take 240 mg by mouth twice daily.	30-day	
		☐ Maintenance Dose: Take 120 mg by mouth twice daily.	28-Day	
☐ Vumerity™	☐ 231 mg capsule	☐ Initial Dose: Take 231 mg by mouth twice daily for seven days. Then, take 462 mg (2x231 mg) by mouth twice daily.	106 Capsules	0
		☐ Maintenance Dose: Take 462 mg (2x231 mg) by mouth twice daily.	30-day	
☐ Zeposia	☐ Starter Kit Kit contains: 4x0.23 mg caps 3x0.46 mg caps 30x0.92 mg caps	☐ Initial Dose: Days 1-4: Take one 0.23 mg capsule by mouth once daily x 4 days Days 5-7: Take one 0.46 mg capsule by mouth once daily x 3 days Day 8 and thereafter: Take one 0.92 mg capsule by mouth once daily	1 Kit	0
	☐ 0.92 mg Capsule	☐ Maintenance Dose: Take one capsule by mouth once daily	☐ 30-day	

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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