## MULTIPLE SCLEROSIS REFERRAL FORM (A-K)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



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

DATIFALT INFORMATION											
PATIENT INFORMATION											
Last Name	First Name	DOB		Gender $\square$ M	□F L	ast 4 SSN	I	Prima	ry Langua	age	
Address			City				State		ZIF	P	
Email	Home Phone			Work Pho	ne			Ce	II Phone		
Primary Contact Method (check one	e) 🗆 Cell Phone 🗆 Home	Phone	☐ Tex	kt 🗆 Email	☐ Prima	ry Caregiver	□ DO N	OT CONT	ACT		
Primary Caregiver/Alt Contact Name	(If applicable)	Alt Contac	ct Email					Alt Co	ontact Ph	one	
PRESCRIBER INFORMATION	١										
Name of Contact Sending Referral		Title			Preferre	ed Contact Me	thod (che	ck one)	□ Email	☐ Phone	□Fax
Referral Contact Email				Office Phone			(	Office Fax			
Practice / Facility Name				Prescriber Na	me / Spe	cialty					
Address			Ci	ty				Sta	te	ZIP	ı
Prescriber State License #	DEA#	NPI # Medicaid UPIN #							PIN#		
	* Please incl	ude a copy of the	fron	t and back	of in	surance ca	ard *				
CLINICAL INFORMATION - F											
ICD-10 Code ☐ G35 Multiple Scle		ibre emiliear emarem	0.00			Date of	Diagnosis	or Years v	with Cond	lition	
· · · · · · · · · · · · · · · · · · ·	essive Relapsing  Primary I	Progressive   Secondary	/ Progra	ssive $\square$ Clinical	ly Isolate					pplicable):	
□ New to Therapy □ Therapy Resta				ssive d Cillical				Lust Rel	abae (II d	Philadie).	
				Other Allergie	-		.100000				
Allergies □ NKDA □ Yes (pleas  Past Meds Tried/Failed (please list)	oe not <i>)</i>			_ Guier Allergie	es (pieas	= 113L <i>)</i>					
	8-45										
Other/Concomitant Medications (ple		ata Baradalah			/!	NA ( - !	/ !!		D-4- 01	a de a de la contra	
Sample/Starter Provided? ☐ No ☐ Y		ate Provided:	Pa	atient Height (c	m/in):	Weight	(kg/lbs):		Date Or	otained:	
Ship to Address ☐ Home ☐ Preso											
PRESCRIPTION INFORMATION IN order for a brand name produced in the produced in				rand Necessal	rv" or "F	Brand Medica	ally Nece	ssarv"			
or your state-specific required la									tions.		
MEDICATION	DOSE	DIRECTIONS								QTY	REFIL
□ Avonex*	☐ 30 mcg PFS ☐ 30 mcg Autoinjector	☐ Maintenance Dose:	Inject 3	0 mcg (0.5 mL)	IM every	7 days.				28-Day (1 Box)	
□ Betaseron <sup>*</sup>	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	ect 0.25 mg (1 mL) SubQ every other day							
	□ 20 mg PFS	☐ Inject 20 mg SubQ	once da	ily						30-day	
-	□ 40 mg PFS	☐ Inject 40 mg SubQ	three ti	mes weekly, at l	least 48 l	nours apart on	the same	3 davs ea	ch week	28-day	
☐ Dalfampridine ER	□ 10 mg Tablet	☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week ☐ 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
☐ Gilenya* *indicate First Dose Observation	□ 0.5 mg capsule	☐ Maintenance Dose: Inject 0.25 mg (1 mL) SubQ every other day  ☐ Take 0.5 mg by mouth once daily. ☐ Continuation of therapy; FDO completed								30-day	
(FDO) status		☐ FDO planned - Dat					30-uay				
☐ Glatiramer Acetate	□ 20 mg PFS	☐ Inject 20 mg SubQ once daily								30-Day	
	☐ 40 mg PFS	☐ Inject 40 mg SubQ			A2ct // A	☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each v					
□ Glatopa	□ 20 mg PFS	☐ Inject 20 mg SubQ once daily								30-Day	
					10031 40 1					1	
	☐ 40 mg PFS	☐ Inject 40 mg SubQ	once da	illy		nours apart on	the same	3 days ea	ch week	28-Dav	
□ Kosimpta	□ 40 mg PFS		once da	nily mes weekly, at l	least 48 I		the same	3 days ea	ch week	28-Day	
☐ Kesimpta  HBV & quantitative serum Ig  screening required before 1st dose		☐ Inject 40 mg SubQ ☐ Loading Dose: Injec ☐ Maintenance Dose:	once da three ti ct 20 mg	mes weekly, at l	least 48 l Q at Wee	ks 0, 1 and 2.		-	ch week	28-Day 3 Units 1 Unit	0

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber

## MULTIPLE SCLEROSIS REFERRAL FORM (L-R)

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	_					-							
PATIENT INFORMATION													
Last Name	First Name	DOB		Gender	□м	□F	Last 4 SS	SN		Prii	mary Langu	ıage	
Address			City	-					State		ZI	IP	
Email	Home Phone			Wo	ork Pho	one					Cell Phone	!	
Primary Contact Method (check one)	Cell Phone  Home	Phone   Work Phon	ie 🗆 To	ext 🗆 E	mail	□ Pr	imary Care	giver	□ DO	NOT CO	NTACT		
Primary Caregiver/Alt Contact Name	(If applicable)	Alt Conta	act Ema	il						Alt	Contact Ph	none	
PRESCRIBER INFORMATION													
Name of Contact Sending Referral		Title				Pref	erred Conta	act Meth	nod (ch	eck one)	☐ Email	☐ Phone	□ Fax
Referral Contact Email		THE		Office	Phone	1101	circa conti		100 (01)	Office F			
Practice / Facility Name						me /	Specialty			OTHICC I	ux .		
Address				City	DC1 140		opeciaity			9	State	ZI	
Prescriber State License #	DEA#			NPI#						Medicaid			
Frescriber State License #		ide a copy of th			hacl	k of	incuran	co co		riculculu	OF IIV #		
				nt and	Daci	( 01	IIISUI aii	ce ca	ru				
CLINICAL INFORMATION - P		ble clinical chart	notes										
ICD-10 Code G35 Multiple Scler	rosis Other:						D	ate of D	iagnos	is or Year	rs with Con	dition	
Type of MS ☐ Relapsing ☐ Progre	ssive Relapsing  Primary P	rogressive   Secondar	ry Progr	essive $\square$	Clinica	lly Iso	late Syndro	ome	Date	of Last F	Relapse (if a	applicable):	
□ New to Therapy □ Therapy Resta	rt		1	Expected	Therap	y Stai	rt Date/Dat	te Med N	leeded				
Allergies □ NKDA □ Yes (please	e list)			□ Other	Allergi	es (pl	ease list)						
Past Meds Tried/Failed (please list)													
Other/Concomitant Medications (plea	ase list)												
Sample/Starter Provided? ☐ No ☐ Ye	es, Provide Qty: Da	te Provided:	ı	Patient He	ight (c	:m/in)	: '	Weight	(kg/lbs	i):	Date O	btained:	
Ship to Address ☐ Home ☐ Presc	riber's Address 🗆 Other (p	olease list)											
PRESCRIPTION INFORMATION				D/ A/-			((D/ A	M1: 1	II N.I		,		
In order for a brand name produc or your state-specific required lar													
MEDICATION	DOSE	DIRECTIONS										QTY	REFILLS
□ Mayzent	□ 0.25 mg tablets	☐ Dose Titration to 1	1 mg:									12	
1 mg daily dosing		<ul> <li>Day 1&amp;2: Take 0.25 mg PO once daily</li> <li>Day 3: Take 0.50 mg PO once daily</li> <li>Day 5+: Take 1 mg PO once daily</li> </ul>								Tablets	0		
		☐ Maintenance Dose	e: Take 1	mg PO or	nce dai	ly						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.											
□ Ocrevus <sup>™</sup>	☐ 300 mg/10 mL SDV	☐ Initial Dose: Infuse two weeks later	300 m	g IV on D	ay 1, fo	llowed	d by a seco	nd 300	mg IV i	nfusion		2 Vials (( Months)	
			☐ Maintenance Dose: Infuse 600 mg IV once every six months (begin 6 months after the first 300 mg dose)								the	2 Vials (( 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*	□ PFS	☐ Loading Dose (22	mcg tai	rget dose)	(PFS	Only):							
Titration Pack Initial Dosing	☐ Rebidose Autoinjector  Titration Packs Contain:	<ul> <li>Weeks 1&amp;2: Inject 4.4 mcg SubQ three times weekly</li> <li>Weeks 3&amp;4: Inject 11 mcg SubQ three times weekly</li> <li>Weeks 5+: Inject 22 mcg SubQ three times weekly</li> </ul>							1 Pack (28-Day)	0			
	6x8.8 mcg devices 6x22mcg devices	Separate doses by at least 48 hours.											
		□ 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 least 48 hours.			).5 mL)	) SubC	three time	es week	ly. Sepa	rate dos	es by at	28-day	
	☐ 44 mcg Autoinjector ☐ 44 mcg PFS		☐ Maintenance Dose: Inject 44 mcg (0.5 mL) SubQ three times weekly. Separate doses by at									28-day	
	□ ++ IIIC9 PF3	least 48 nours.											
Prescriber Signature		Date		Supervisi	ng Phy	sician	Signature	(where i	require	d by state	e law)	Date	
DAW (Dispense as Written)	<del></del>	Date		Brand Ne	cessar	y (mus	st handwrit	e)					

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## **MULTIPLE SCLEROSIS** REFERRAL FORM (S-Z)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



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Kemove above portion	Derore raxi	rig. Flease con	ipiete t	ne prescript	1011 101	111 111	its entire	ty aric	JIAX WILIT	secui	e cover s	neet	to the n	urriber abo	/e.
PATIENT INFORMATION															
Last Name	First Name			DOB			nder 🗆 M	□F	Last 4 SSN	Primary L		imary Lar	nguage		
Address					City						State			ZIP	
Email		Home Phone					Work Pho	ne					Cell Pho	ne	
Primary Contact Method (check one)	☐ Cell Pho	ne 🗆 Home Pl	none	☐ Work Phone	e 🗆 T	ext	□ Email	□ Pri	mary Careg	iver		от со	NTACT		
Primary Caregiver/Alt Contact Name	(If applicable	)		Alt Conta	ct Ema	il						Alt	t Contact	Phone	
PRESCRIBER INFORMATION															
Name of Contact Sending Referral			1	Γitle				Prefe	erred Contac	ct Met	hod (chec	k one)	) □ Em	ail 🗆 Phone	₽□Fax
Referral Contact Email						Of	fice Phone				0	ffice F	Fax		
Practice / Facility Name						Pre	escriber Na	me / S	Specialty						
Address					(	City						:	State	7	ZIP
Prescriber State License #	DE	A #			ı	NPI #					Me	dicaid	UPIN#		
	* <b>P</b>	lease includ	de a c	opy of the	e fro	nt a	nd back	cofi	insuranc	e ca	ard *				
CLINICAL INFORMATION - P	lease incl	ude applicab	le clin	ical chart r	notes										
ICD-10 Code G35 Multiple Scler	osis 🗆 Othe	r:							Da	te of I	Diagnosis (	or Yea	rs with C	ondition	
Type of MS ☐ Relapsing ☐ Progre	ssive Relapsi	ng 🗆 Primary Pro	gressive	e 🗆 Secondar	y Progr	essive	e 🗆 Clinica	lly Isol	ate Syndror	ne	Date of	f Last	Relapse (	(if applicable	):
☐ New to Therapy ☐ Therapy Resta	rt 🗆 Existir	ng Treatment			ı	Expec	ted Therap	y Star	t Date/Date	Med	Needed				
Allergies □ NKDA □ Yes (please	e list)					□ Ot	ther Allergi	es (ple	ease list)						
Past Meds Tried/Failed (please list)															
Other/Concomitant Medications (plea	ise list)														
Sample/Starter Provided? $\square$ No $\square$ Ye	s, Provide Q	ty: Date	e Provid	ed:	1	Patien	nt Height (c	m/in):		Veight	(kg/lbs):		Date	Obtained:	
Ship to Address ☐ Home ☐ Presc	riber's Addre	ss 🗆 Other (pl	ease list	)											
PRESCRIPTION INFORMATIO															
In order for a brand name produc or your state-specific required lar															
	DOSE		DIRECT				, , , , , , , , , , , , , , , , , , , ,							QTY	REFILLS
	☐ Titration / Starter Pack ☐ Initial Dose: Take 120 r					bv mc	outh twice o	daily fo	or seven day	/s. The	en. take 24	0 ma	bv moutl		
	14 x 120 mg 46 x 240 mg	capsules	twice daily.									30-da	y		
	□ 240 mg ca	-	☐ Maintenance Dose: Take			40 m	a by mouth	twice	daily.					30-da	,
	□ 120 mg ca		☐ Maintenance Dose: Take 120 mg by mouth twice daily.					-					28-Da		
□ Vumerity™	☐ 231 mg ca <sub>l</sub>	osule				g by mouth twice daily for seven days. Then, take 462 mg							106		
			(2x231 mg) by mouth to									Capsul	es O		
			☐ Main	tenance Dose:	Take 4	e 462 mg (2x231 mg) by mouth twice daily.								30-da	y
□ Zeposia	☐ Starter Kit		l Dose:	0.23 mg capsule by mouth once daily x 4 days											
	Kit contains: Days 5-7: Take one 0.46						ng capsule by mouth once daily x 3 days ke one 0.92 mg capsule by mouth once daily							1 Kit	0
	3x0.46 mg c	aps	Day 8 a	and thereafter	: Take c	one O.	.92 mg caps	sule by	/ mouth onc	e dail	У				
<del> </del>	30x0.92 mg														
	□ 0.92 mg C	apsule	□ Main	tenance Dose:	Take o	ne ca	psule by m	outh o	nce daily					□ 30-d	ау
Prescriber Signature		D	ate			Supe	rvising Phy	sician	Signature (\	where	required b	y stat	te law)	Date	
DAW (Dispense Maile )			-4-			Branc	d Necessarı	/ (mus	t handwrite	)					
DAW (Dispense as Written)		D	ate							-					

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