MULTIPLE SCLEROSIS REFERRAL FORM

A-D

Phone: (888) 370.1724 Fax: (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
SSN	Allergies	
Sex ❑ Male ❑ Female	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax		

Clinical Information

Diagnosis: _____ ICD10 Code: _____
Number of Relapses in past year: _____
Last MRI Date: _____ Any MRI Changes? ❑ YES ❑ NO
Is patient pregnant, nursing or planning pregnancy? ❑ YES ❑ NO

Has patient previously been treated for this condition? ❑ YES ❑ NO
Prior Failed Medication (Medication, Duration of Treatment, Reason for d/c):
_____
Is patient currently on therapy? ❑ YES ❑ NO
Will patient discontinue therapy prior to starting new therapy? ❑ YES ❑ NO
Discontinuation Date: _____

Medication	Dose/Strength	Sig	Qty.	Refills
❑ **Avonex®**	❑ 30 mcg Prefilled Syringe ❑ 30 mcg Pen ❑ 30 mcg Lyophilized Vial	❑ Dose Titration (PFS only) - Requires AVOSTARTGRIP kit) • Week 1: 7.5 mcg IM once weekly • Week 2: 15 mcg IM once weekly • Week 3: 22.5 mcg IM once weekly • Week 4+: 30 mcg IM once weekly	28-day	0
		❑ Maintenance Dose: 30mcg IM once weekly	28-day	____
❑ **Betaseron®**	❑ 0.3 mg vial kit	❑ Dose Titration: • Weeks 1&2: 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: 0.25 mg (1mL) SubQ every other day	56-day	0
		❑ Maintenance dose: 0.25 mg (1 mL) SubQ every other day	28-day	____
❑ **Copaxone®**	❑ 20 mg Prefilled Syringe	❑ Inject 20 mg SubQ once daily	30-day	____
	❑ 40 mg Prefilled Syringe	❑ Inject 40 mg SubQ 3 times a week, 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 (12 hours apart)	30-day	____

Injection training needed by Amber Pharmacy? ❑ YES ❑ NO Deliver to: ❑ Home ❑ Office ❑ Other: _____

❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer therapy as needed. If shipped to prescriber's office, prescriber accepts on behalf of patient for administration in office.

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 substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

MULTIPLE SCLEROSIS REFERRAL FORM

E-P

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10004 S. 152nd St, Suite A, Omaha NE 68138

Amber PHARMACY

Patient Information

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Last Name	First Name	DOB
Address		
City	State	ZIP
SSN	Allergies	
Sex ❑ Male ❑ Female	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax		

Clinical Information

Diagnosis: _____ ICD10 Code: _____
Number of Relapses in past year: _____
Last MRI Date: _____ Any MRI Changes? ❑ YES ❑ NO
Is patient pregnant, nursing or planning pregnancy? ❑ YES ❑ NO

Has patient previously been treated for this condition? ❑ YES ❑ NO
Prior Failed Medication (Medication, Duration of Treatment, Reason for d/c):
_____
Is patient currently on therapy? ❑ YES ❑ NO
Will patient discontinue therapy prior to starting new therapy? ❑ YES ❑ NO
Discontinuation Date: _____

Medication	Dose/Strength	Sig	Qty.	Refills
❑ **Extavia®**	❑ 0.3 mg vial	❑ Dose Titration: • Weeks 1&2: 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: 0.25mg (1 mL) SubQ every other day	56-day	0
		❑ Maintenance dose: 0.25 mg (1 mL) SubQ every other day	28-day	_____
❑ **Gilenya®**	❑ 0.5 mg capsule	❑ Take one capsule by mouth daily, with or without food ❑ Continuation of therapy: first dose observation completed ❑ First dose observation planned	30-day	_____
❑ **Ocrevus™**	❑ 300 mg/10 mL Vial	❑ Initial Dose: Infuse 300mg IV on Day 1, followed by 300 mg IV infusion 2 weeks later	6-month	0
		❑ Subsequent Doses: Infuse 600mg IV once every 6 months (beginning 6 months after the first 300 mg dose)	6-month	_____
❑ **Plegridy®:**	❑ *Autoinjector Pen* ❑ *Prefilled Syringe*	❑ Starter Pack *Day 1: Inject 63 mcg* SubQ *Day 15: Inject 94 mcg* SubQ	28-day	0
		❑ *Maintenance Dose* *Inject 125 mcg* SubQ *every 14 days*	84-day	_____

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R-V

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Amber PHARMACY

Patient Information

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Last Name	First Name	DOB
Address		
City	State	ZIP
SSN	Allergies	
Sex ❑ Male ❑ Female	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
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Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
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Clinical Information

Diagnosis: _____ ICD10 Code: _____
Number of Relapses in past year: _____
Last MRI Date: _____ Any MRI Changes? ❑ YES ❑ NO
Is patient pregnant, nursing or planning pregnancy? ❑ YES ❑ NO

Has patient previously been treated for this condition? ❑ YES ❑ NO
Prior Failed Medication (Medication, Duration of Treatment, Reason for d/c):
_____
Is patient currently on therapy? ❑ YES ❑ NO
Will patient discontinue therapy prior to starting new therapy? ❑ YES ❑ NO
Discontinuation Date: _____

Medication	Dose/Strength	Sig	Qty.	Refills
❑ **Rebif®**	❑ Titration Pack - Prefilled Syringe ❑ Titration Pack - Rebidose® Pen Contains: 6x8.8 mcg devices 6x22 mcg devices	❑ Loading dose (**22 mcg target dose**) - Prefilled Syringes **ONLY** Weeks 1&2: Inject 4.4 mcg SubQ 3 times weekly Weeks 3&4: Inject 11 mcg SubQ 3 times weekly Weeks 5+: Inject 22 mcg SubQ 3 times weekly **Dose should be separated by at least 48 hours.* ❑ Loading dose (**44 mcg target dose**) - Rebidose® Pen -or- Prefilled Syringes Weeks 1&2: Inject 8.8 mcg SubQ 3 times weekly Weeks 3&4: Inject 22 mcg SubQ 3 times weekly Weeks 5+: Inject 44 mcg SubQ 3 times weekly **Dose should be separated by at least 48 hours.*	28-day 28-day	0 0
❑ **Rebif® Rebidose** ❑ **Rebif® Prefilled Syringes**	❑ 22 mcg/0.5 mL ❑ 44 mcg/0.5 mL	❑ Maintenance dose: Inject SubQ3 times weekly. **Dose should be separated by at least 48 hours.*	28-day	____
❑ **Tecfidera®:**	❑ Titration / Starter Pack 14 x 120mg capsules 46 x 240mg capsules	❑ Take 120 mg by mouth twice daily x7 days, then take 240 mg by mouth twice daily ❑ Other:_____	30-day	0
	❑ 240 mg capsule	❑ Maintenance Dose: Take one capsule by mouth twice daily	30-day	____
❑ **Vumerity™:**	❑ Starter Dose	❑ Take 231 mg by mouth twice daily x7 days, then take 462 mg (2 x 231 mg) by mouth twice daily ❑ Other:_____	30-day	0
	❑ 231 mg capsule	❑ Maintenance Dose: Take 462 mg (2 x 231 mg) by mouth twice daily	30-day	____

***Note: Rebif should be administered, if possible, at the same time (preferably in the late afternoon or evening) on the same 3 days (e.g., Monday, Wednesday and Friday) Doses should be separated by at least 48 hours.)**

Injection training needed by Amber Pharmacy? ❑ YES ❑ NO Deliver to: ❑ Home ❑ Office ❑ Other: _____

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