Multiple Sclerosis Referral Form

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

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Gender (M/F)	Weight/Recorded Date	Date of Birth	Allergies

Emergency Contact	Phone	Primary Caregiver	Phone

Healthcare Provider Information:

Practice/Facility Name	Physician Name	Phone/Fax

Address	City	State	ZIP

Physician NPI #	Nurse/Key Contact	Phone or Pager Number	Email

Delivery Information:

Insurance and Clinical Information: *PLEASE FAX A COPY OF INSURANCE CARD (FRONT AND BACK)*

Diagnosis: _____ ICD10 Code: _____
Has patient previously been treated for this condition? ☐ YES ☐ NO
Is patient currently on therapy? ☐ YES ☐ NO
Number of Relapses in past year: _____
Will patient discontinue therapy prior to starting new therapy? ☐ YES ☐ NO
Discontinuation Date: _____
Prior Failed Medication (Medication, Duration of Treatment, Reason for d/c):
_____

Is patient pregnant, nursing or planning pregnancy? ☐ YES ☐ NO
Last MRI Date: _____ Any MRI Changes? ☐ YES ☐ NO
Injection Training Needed by Amber Pharmacy? ☐ YES ☐ NO
Novantrone: Is patient's LVEF <50%? ☐ YES ☐ NO
What is lifetime (cumulative) Novantrone dose (mg/m2)? _____
Copy of last CBC with differential: _____
☐ Serum Creatine: _____ ☐ Creatinine Clearance: _____

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Avonex®**	☐ 30mcg Prefilled Syringe #4 ☐ 30mcg Pen #4	☐ Inject 30mcg IM once weekly	4 week supply	
☐ **Betaseron®**	☐ 0.3mg vial	☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml SC QOD • Weeks 3-4: Inject 0.125mg/0.50ml SC QOD • Weeks 5-6: Inject 0.1875mg/0.75ml SC QOD • Weeks 7+: Inject 0.25mg/1ml SC QOD ☐ Maintenance Dose: 0.25mg/1ml SC QOD ☐ Other:	4 week supply	
☐ **Copaxone®**	☐ 20mg Prefilled Syringe ☐ 40mg Prefilled Syringe	☐ 20mg SC QD ☐ 40mg SC QD	4 week supply 4 week supply	
☐ **Extavia®**	☐ 0.3mg vial	☐ Maintenance Dose: 0.25mg/1ml SC QOD ☐ Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml SC QOD • Weeks 3-4: Inject 0.125mg/0.50ml SC QOD • Weeks 5-6: Inject 0.1875mg/0.75ml SC QOD • Weeks 7+: Inject 0.25mg/1ml SC QOD ☐ Other:	4 week supply 4 week supply	
☐ **Gilenya®**	☐ 0.5mg capsule	☐ 0.5mg PO QD		
☐ **Rebif®**	☐ Titration Pack (8.8mcg/22mcg) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe	☐ Inject 8.8mcg SC three times a week for weeks 1-2, 22mcg SC three times a week weeks 3-4, and 44mcg SC three times a week weeks 5+ (48 hours apart) ☐ Maintenance: Inject 22mcg (0.5ml) SC three times a week (48 hours apart) ☐ Maintenance: Inject 44mcg (0.5ml) SC three times a week (48 hours apart) ☐ Other:	4 week supply	
☐				

*****When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards*****

Physician Signature:_____ ☐ **DAW** (Dispense as Written) **Date** ____/____/____