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** ____/____/____

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.