# Multiple Sclerosis Prescription Referral Form

Carepoint Pharmacy
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**Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart**

| First Name | Middle Initial | Last Name | Date of Birth | Gender ◯M ◯F | Social Security Number |
|---|---|---|---|---|---|
| | | | | | |

Street:

| City | State | Zip Code | Home Phone | Work Phone | Cell Phone |
|---|---|---|---|---|---|
| | | | | | |

**Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card**

| Insurance Carrier Name - Primary | Name of Insured | Relationship | ID# | Group Number | Insurance Phone |
|---|---|---|---|---|---|
| | | | | | |
| **Rx-Carrier Name -Secondary** | **Rx ID#** | **Rx Group #** | **Rx Phone #** | | |
| | | | | | |

**Complete Drug Therapy Information in Section Below OR Attach Completed Prescription**

| Drug Name | Form/Strength/Directions for Use | Qty | Refills |
|---|---|---|---|
| Avonex | ☐ 30 mcg IM QW Pre- fills ☐ 30 mcg IM QW Prefilled Pen device ☐ 30 mcg IM QW Vials ☐ 1yr ☐ Avonex short needles, 1" 25g ☐ Other: _____ | | |
| Betaseron | Initial dosing: Titration: Weeks 1-2 :25% 0.0625 mg /0.25 mL every other day SC then Weeks 3-4: ☐ 50% 0.125 mg /0.50 mL every other day SC: Weeks 5-6: 75% 0.1875 mg/ 0.75 mL every other day SC then Week 7+: 100% 0.25 mg /1.0 mL every other day SC ☐ Ongoing Treatment: 250 mcg SC every other day ☐ 1year ☐ Other: _____ | | |
| Copaxone | ☐ 20 mg SC Daily Pre - fills ☐ 1year ☐ 40 mg SC TIW Pre - fills ☐ 1year | | |
| Extavia | Initial dosing: Titration: Weeks 1-2 :25% 0.0625 mg /0.25 mL every other day SC then Weeks 3-4: ☐ 50% 0.125 mg /0.50 mL every other day SC: Weeks 5-6: 75% 0.1875 mg/ 0.75 mL every other day SC then Week 7+: 100% 0.25 mg /1.0 mL every other day SC ☐ Ongoing Treatment: 250 mcg SC every other day ☐ 1year ☐ Other: _____ | | |
| Gilenya | ☐ 0. 5 mg daily by mouth ☐ 1year | | |
| Plegridy | ☐ Initial dose: 63mcg SC day 1, then 94mcg SC day 15, then 125mg SC day 29 ☐ Ongoing treatment: 125mcg SC every 14 days ☐ 1year ☐ Other: _____ | | |
| Rebif | ☐ Prefills ☐ Rebidose ☐ Initial dose: Titration Pack : 8.8 mcg SC TIW x 2 weeks, Then 22 mcg SC TIW x 2 weeks ☐ Ongoing Treatment: 44 mcg SC TIW ☐ 22 mcg SC TIW ☐ 1year ☐ Other: _____ | | |
| Tecfidera | ☐ Initial dose: Starter pack : 120 mg BID by mouth for 7 days then 240mg BID by mouth ☐ Ongoing Treatment: 240mg BID by mouth ☐ 1year ☐ Other: _____ | | |
| Nuedexta | ☐ Starting dose: One capsule PO daily for 7 days ☐ Ongoing Treatment : One capsule PO every 12 hours | | |

**Clinical Data**

| Primary Diagnosis: | | ICD - 10: | | Weight: | pounds Height: | inches |
|---|---|---|---|---|---|---|

Allergies: Failed Therapies:

Please provide current list of medications:

**Complete Prescriber Information in Section Below NOT Included on Attached Prescription**

| MD First Name | MD Last Name | DEA # | UPIN | State License # | NPI |
|---|---|---|---|---|---|
| | | | | | |

| Office Address: | | | | | |
|---|---|---|---|---|---|
| City: | | State: | | Zip: | |
| Office | | Office Fax: | | | |
| Office Contact Name: | | Office E-mail: | | | |

**SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS**

☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.* TLC/JS 9/15/15

| **Dr:** *Substitution Permitted* | **Dr:** *No Substitution Permitted* | **Date:** |
|---|---|---|
| | | |