MULTIPLE SCLEROSIS **A-D**

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



Patient Infor	mation	PLEAS	E FAX IN	SURANCE	CAR	D (FRONT AND	BACK)	P	Prescriber Info	ormation			
Last Name First Name					DOB			Practice/Facility Name					
Address	ľ							A	ddress				
City State					ZIP			Ci	ity	State		ZIP	
SSN		•	Allergies		I			Prescriber Name					
Sex 🛛 Male 🗖	Female	Weight (kg)			He	eight (ft,in)		Pi	rescriber NPI				
Emergency Contact				Phone	e			Nurse/Key Contact Pho			none/Pager		
Insurance Plan				Plan ID #				Fa	эх				
Clinical Infor	mation												
Diagnosis: Number of Relaps Last MRI Date: Is patient pregnar		ear: Any MR	I Change	es? 🗖 YES		NO	Prior Faile	ed M cui nt c	previously been tre Medication (Medic rrently on therapy discontinue therap ion Date:	ation, Duration ?	of T	reatment, Reasor	n for d/c):
Medication	Dose/S	Strengt	h	Si	g							Qty.	Refills
□ Avonex®	 30 mcg Prefilled Syringe 30 mcg Pen 30 mcg Lyophilized Vial 				 Dose Titration (PFS only) - Requi Week 1: 7.5 mcg IM once we Week 2: 15 mcg IM once we Week 3: 22.5 mcg IM once we Week 4+: 30 mcg IM once we 			eeki eeki wee	ly y :kly	t)		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. Weeks 3&4: 0.125 mg (0.5 Weeks 5&6: 0.1875 mg (0.7 Weeks 7+: 0.25 mg (1mL) \$ Maintenance dose: 0.25 mg (1) SubQ every other mL) SubQ every ot	day		56-day	0
									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 we on the same 3 days each week.						28-day		
Dalfampridine ER	□ 10 mg ⁻	Tablet			Take	e 10 mg by mout	h twice daily	y (1	2 hours apart)			30-day	

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)

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MULTIPLE SCLEROSIS REFERRAL FORM



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



Patient Information	PLEASE FAX INSURANCE CARD (FRONT AND					BACK)	Prescriber Information						
Last Name	First Name			DO	В		Practice/Facility Name						
Address							Address						
City	State				ZIP		City	State	ZIP				
SSN		Allergies					Prescriber Name						
Sex 🖸 Male 🖬 Female	Weight (kg)			Height (ft,in)			Prescriber NPI						
Emergency Contact			Phone				Nurse/Key Contact		Phone/Pager				
Insurance Plan			Plan ID #			Fax							
Clinical Information													
Diagnosis: Number of Relapses in past Last MRI Date: Is patient pregnant, nursing	year: Any MRI	Change			I NO] NO	Prior Faile Is patient Will patier	d Medication (Medic currently on therapy	ation, Duration o	ndition? YES NO of Treatment, Reason for d/c):				

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	
Degridy®:	 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	

Deliver to: Home Office Other:

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Patient Information	PLEAS	e fax ins	SURANCE C	CARD (FRONT AND BACK)			Prescriber Information				
Last Name	First Name	irst Name			3		Practice/Facility Name				
Address			Address								
City State					ZIP		City		State ZIP		ZIP
SSN Allergie						Prescriber Name					
Sex 🖸 Male 🖬 Female	Male Female Weight (kg)			Height (ft,in)			Prescriber NPI				
Emergency Contact			Phone				Nurse/Key Contact		Pho	Phone/Pager	
Insurance Plan			Plan ID #				Fax				
Clinical Information											
Diagnosis: Number of Relapses in past Last MRI Date: Is patient pregnant, nursing	year: Any MR	Change			NO NO	Prior Faile	d Medication	(Medic		of Tr	ion?
	Will patient discontinue therapy prior to starting pow therapy $2 \square \text{VES} \square \text{NO}$										

Will patient discontinue therapy prior to starting new therapy? I YES I NO Discontinuation Date: _____

Medication	Dose/Strength	Sig	Qty.	Refills
□ Rebif®	 Titration Pack - Prefilled Syringe Titration Pack - Rebidose[®] Pen Contains: 	□ 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.	28-day	0
	6x8.8 mcg devices 6x22 mcg devices	□ 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	0
	□ 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	A 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.)

Deliver to: Deliver to: Office Office Office Office

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