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NEUROLOGY MS REFERRAL FORM

Date: ___/___/___ Needs by Date: _____

Language: _____ Nursing Instruction Required

Ship to: Patient MD Office

Prescriber's Name: _____ DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: ___/___/___ Gender: F M

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

Diagnosis: CM G35 Multiple Sclerosis <input type="checkbox"/> Other: _____ Has the patient been previously treated for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior failed medication (medication and duration of treatment/reason for d/c): <input type="checkbox"/> _____ Patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ Will patient be stopping above medication before starting new therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Discontinuation Date: _____ Is prescribe a Neurologist? If no, please include neurology consult if available. Diagnosis: <input type="checkbox"/> Other: _____	Number of relapses in past year: _____ Last MRI date: _____ Any MRI changes? <input type="checkbox"/> Yes <input type="checkbox"/> No Injection training completed by: Novantrone: Is patient's LVEF <50%? <input type="checkbox"/> Yes <input type="checkbox"/> No What is lifetime (cumulative) Novantrone dose (mg/m2)? _____ Copy of last CBC with differential: _____ Is patient pregnant, nursing or planning pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Serum Creatinine _____ <input type="checkbox"/> Creatinine Clearance _____
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PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
<input type="checkbox"/> AVONEX (interferon beta-1a)	<input type="checkbox"/> 30mcg prefilled syringe - Inject intramuscularly once a week <input type="checkbox"/> 30mcg single dose vial - Inject intramuscularly once a week	<input type="checkbox"/> 4-Week supply (1 kit) <input type="checkbox"/> 12-Week supply (3 kits)	
<input type="checkbox"/> BETASERON (interferon beta-1b)	<input type="checkbox"/> 0.3mg - Inject 0.25mg (1ml) subcutaneously every other day <input type="checkbox"/> Dose Titration • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD (every other day) • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD (every other day) • Weeks 5-6: Inject 0.1875mg/0.75ml subcutaneously QOD (every other day) • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD (every other day)	<input type="checkbox"/> 28-Day supply (1 kit of 14 vials) <input type="checkbox"/> 84-Day supply (3 kits of 14 vials) <input type="checkbox"/> Other:	
<input type="checkbox"/> COPAXONE (glatiramer acetate injection)	<input type="checkbox"/> 20mg prefilled syringe - Inject subcutaneously daily	<input type="checkbox"/> 30-Day supply (1 kit) <input type="checkbox"/> 90-Day supply (3 kits)	
<input type="checkbox"/> EXTAVIA (interferon beta-1b)	<input type="checkbox"/> 0.3mg - Inject 0.25mg (1ml) subcutaneously every other day <input type="checkbox"/> Dose Titration • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD (every other day) • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD (every other day) • Weeks 5-6: Inject 0.1875mg/0.75ml subcutaneously QOD (every other day) • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD (every other day)	<input type="checkbox"/> 30-Day supply (1 kit) <input type="checkbox"/> 90-Day supply (3 kits)	
<input type="checkbox"/> GILENYA (fingolimod capsules)	<input type="checkbox"/> 0.5mg - Take one capsule by mouth daily	<input type="checkbox"/> 28-Day supply (1 kit) <input type="checkbox"/> 84-Day supply (3 kits) <input type="checkbox"/> Other:	
<input type="checkbox"/> OCREVUS <input type="checkbox"/> Initial Dose (two infusions) <input type="checkbox"/> Subsequent Doses (one infusion)	<input type="checkbox"/> Infusion 1: 300 mg in 250 ml <input type="checkbox"/> Infusion 2 (2 weeks later): 300 mg in 250 ml <input type="checkbox"/> One infusion every 6 months: 600 mg in 500 ml	• Start at 30 ml per hour • Increase by 30 ml per hour every 30 minutes • Maximum: 180 ml per hour • Duration: 2.5 hours or longer • Start at 40 ml per hour • Increase by 40 ml per hour every 30 minutes • Maximum: 200 ml per hour • Duration: 3.5 hours or longer	
<input type="checkbox"/> REBIF (interferon beta-1a) <input type="checkbox"/> 22mcg prefilled syringe <input type="checkbox"/> 44mcg prefilled syringe <input type="checkbox"/> Titration pack (six 8.8mcg & six 22mcg prefilled syringes)	<input type="checkbox"/> Weeks 1-2: Inject 8.8mcg subcutaneously 3 times a week Weeks 3-4: Inject 22mcg subcutaneously 3 times a week Week 5: Inject 44mcg subcutaneously 3 times a week <input type="checkbox"/> Inject 44mcg subcutaneously 3 times a week <input type="checkbox"/> Other:	<input type="checkbox"/> 4-Week supply (1 kit) <input type="checkbox"/> 12-Week supply (3 kits) <input type="checkbox"/> Other:	
<input type="checkbox"/> TYSABRI (natalizumab)	<input type="checkbox"/> 20mg prefilled syringe Directions: _____	<input type="checkbox"/> Enter quantity/duration: _____	

NEWLY APPROVED THERAPIES

Physician Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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