Faxed prescription will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

MS Prescription Referral Form

1403 Highway 6 Suite 700A, Sugar Land, TX 77478 Phone: 832.944.6112 Fax: 832.944.6116

Patient Information

Patient Name: ______ Birthdate: ______ Sex: _____ Male _____ Female Height: ______ Weight: _____ lbs. _____kg.

Soc. Sec. #: ______ Preferred Phone: ______ Known Allergies: ______

Address: ______ City: ______ State: ______ Zip: ______

Alternate Caregiver Name: ______ Preferred Phone: ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (prescription and medical)

Prescriber Information

Name: ______ DEA#: ______ NPI#: ______ Tax ID#: ______

Address: ______ Phone: (_______) _______ - ______ Fax: (_______) _______ - ______

City: ______ State: ______ Zip: ______ Key Contact: ______ Phone: (_______) _______ - ______

Diagnosis/Clinical Information

Please FAX recent clinical notes, Labs, Tests, with the prescription to expidite the Prior Authorization

Diagnosis: ______ 340 Multiple Sclerosis Other: ______

Has the patient been previously treated for this condition? __ Yes __ No

Prior failed medication (medication and duration of treatment/reason for d/c):

______

Patient currently on therapy? __ Yes __ No Medication(s): ______

Will patient be stoping above medication before starting new therapy?

__ Yes __ No Discontinuation Date: ______

Is prescriber a Neurologist? If no, please include neurology consult if available.

Diagnosis: ______ Other: ______

Number of relapses in year: ______

Last MRI date: ______ Any MRI changes? __ Yes __ No

Injection training completed by: ______

Novantrone:

Is patient's LVEF<50%? __ Yes __ No

What is lifetime (cumulative) Novantrone dose (mg/m2)? ______

Copy of last CBC with differential: ______

Is patient pregnant, nursing or planning pregnancy? __ Yes __ No __ N/A

Serum Creatine: ______ Creatinum Clearance: ______

Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
__ Avonex®	__ 30mcg Prefilled Syringe #4 __ 30mcg Pen #4	__ Inject 30mcg IM once a weekly	4 week supply	
__ Betaseron®	__ 0.3mg vial	__ **Dose Titration:** • Weeks 1-2: Inject 0.0625/0,25ml suncotaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcotaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75ml subcotaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcotaneously QOD __ **Maintenance Dose:** 0.25mg/1ml subcotaneously QOD __ **Other:** ______		
__ Copaxone®	__ 20mg Prefilled Syringe	__ 20mg SQ QD	4 week supply	
__ Extavia®	__ 0.3mg vial	__ **Dose Titration:** • Weeks 1-2: Inject 0.0625/0,25ml suncotaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcotaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75ml subcotaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcotaneously QOD __ **Maintenance Dose:** 0.25mg/1ml subcotaneously QOD __ **Other:** ______	4 week supply	
__ Gilenya® (Mycophenolic Acid)	__ 0.5mg capsule	Take 0.5mg SQ QD	4 week supply	
__ Rebif® __ Rebif Rebidose®	__ Titration Pack (8.8mcg/22mcg) __ 22mcg Prefilled Syringe __ 44mcg Prefilled Syringe	__**Inject** 8.8mcg subcotaneously three times a week weeks 1-2 22mcg subcotaneously three times a week weeks 3-4, and 44mcg subcotaneously three times a week weeks 5+ (48 hours apart) __ **Maintenance:** Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) __ **Maintenance:** Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) __ **Other:** ______	4 week supply	

Date Medication Needed: ____/____/______ **Ship To:** ____ Patient's Home _____ Prescriber's Office _____ Pick-up (store location): _________ Injection Training by Pharmacy

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: **Date:**

Prescriber Signature: Prescriber, please sign and date below

Dispense as written **Date:** **Substitution Permissable** **Date**

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recepient, do not dessiminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permittted per order form. Please use a new form for additional items.

# of Prescriptions: _______