MULTIPLE SCLEROSIS REFERRAL FORM

BIOMATRIX SPRX **TEL:** 855-359-9679 **FAX:** 610-545-6030

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Code ☐ G35 Multiple Sclerosis OR ☐ Other_____ Patient Weight _____
☐ Relapse Remitting ☐ Primary Progressive ☐ Secondary Progressive
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work _____
Comments_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AMPRYRA** (dalfampridine) **10 mg extended release tablet**
SIG: ☐ _____ mg PO twice daily QTY:_____ Refills: _____

☐ **AUBAGIO** (teriflunomide)
SIG: ☐ 7 mg: 1 tablet by mouth daily with or without food
SIG: ☐ 14 mg: 1 tablet by mouth daily with or without food
QTY:_____ Refills: _____

AVONEX ADMINISTRATION PACK (interferon beta-1a)
Dose: ☐ 30 mcg PreFilled Syringe ☐ 30 mcg Autoinject Pen
SIG: ☐ Inject 30 mcg IM once weekly
SIG: ☐ Other _____
QTY: # _____ (1 pack = 4 week supply) Refills: _____

☐ **BETASERON** (interferon beta-1b) **0.3 mg Vials**
SIG: ☐ Inject _____ subcutaneously every other day
SIG: ☐ Other _____
QTY: # _____ (1 pack = 4 week supply) Refills: _____

☐ **COPAXONE** (glatiramer acetate)
Dose: ☐ 20 mg Syringe ☐ 40 mg Syringe
SIG: ☐ Inject 20 mg subcutaneously once daily
SIG: ☐ Inject 40 mg subcutaneously three times a week
SIG: ☐ Other _____
QTY:_____ Refills: _____

☐ **GLATIRAMER ACETATE**
Dose: ☐ 20 mg Syringe ☐ 40 mg Syringe
SIG: ☐ Inject 20 mg subcutaneously once daily
SIG: ☐ Inject 40 mg subcutaneously three times a week
SIG: ☐ Other _____
QTY:_____ Refills: _____

☐ **LEMTRADA** (alemtuzumab) **12 mg/1.2 mL**
SIG: _____ QTY:_____ Refills: _____

☐ **GILENYA** (fingolimod) **0.5 mg** *(first dose must be taken at the doctor's office)*
SIG: ☐ Take 1 Capsule by mouth daily QTY:_____ Refills: _____

☐ **EXTAVIA VIALS** (interferon beta-1b) **0.3 mg**
SIG: ☐ Inject _____ subcutaneously every other day
SIG: ☐ Other _____
QTY: # _____ (1 pack = 4 week supply) Refills: _____

☐ **OCREVUS** (ocrelizumab) **300 mg/10 mL**
Loading Dose: ☐ Infuse 300 mg IV on Day 1 followed by 300 mg IV 2 weeks later QTY: 2 Vials
Maintenance Dose *(beginning 6 months after first 300 mg dose)*
☐ Infuse 600 mg IV once every 6 months
QTY:_____ Refills: _____

☐ **REBIF TITRATION PACK** (interferon beta-1a) **12 syringes**
☐ **REBIDOSE Auto Injector**
SIG: ☐ 8.8 mcg subcutaneously TIW - weeks 1 & 2
SIG: ☐ 22 mcg subcutaneously TIW - weeks 3 & 4
Maintenance Dose following week 3 & 4

☐ **REBIF** (interferon beta-1a) **22 mcg/0.5ml**
☐ **REBIDOSE Auto Injector**
SIG: 22 mcg (0.5ml) subcutaneously TIW (48hrs apart)
QTY:_____ Refills: _____

☐ **REBIF** (interferon beta-1a) **44 mcg/0.5ml (maint. starting wk 5)**
☐ **REBIDOSE Auto Injector**
SIG: 44 mcg (0.5ml) subcutaneously TIW (48hrs apart)
QTY # _____ Boxes *(1 box = 4 week supply)* Refills: _____

☐ **TYSABRI** (natalizumab) **300 mg IV**
SIG: ☐ Infuse 300mg IV over 1 hour every 4 weeks
QTY:_____ Refills: _____

OTHER _____
SIG:_____
QTY:_____ Refills: _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____
Prescriber's Email_____