

MULTIPLE SCLEROSIS REFERRAL FORM

210 Rock Road | Glen Rock, NJ 07452
TEL: 201-444-3200 | FAX: 201-444-5792
Toll Free: 866-888-3200

Today's Date _____

CURRENT PATIENT
 NEW PATIENT

FEB 2018

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	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION			
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

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 Diagnosis Code G35 Multiple Sclerosis OR Other _____ Patient Weight _____
Patient currently on therapy Yes No Date of next blood work _____
Comments _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AUBAGIO

SIG: 7mg: 1 tablet by mouth daily with or without food
SIG: 14mg: 1 tablet by mouth daily with or without food
Qty: _____ Refills: _____

AVONEX ADMINISTRATION PACK

30mcg PreFilled Syringe **30mcg Autoinject Pen**

SIG: Inject 30mcg IM once weekly
SIG: Other _____
QTY # _____ (1 pack = 4 wk supply) Refills: _____

BETASERON 0.3mg Vials

SIG: Inject _____ SQ every other day
SIG: Other _____
QTY # _____ (1 box = 4 wk supply) Refills: _____

COPAXONE **20mg Syringe** **40mg Syringe**

SIG: Inject 20mg SQ once daily
SIG: Inject 40mg SQ three times a week
SIG: Other _____
QTY: _____ Refills: _____

EXTAVIA VIALS 0.3 mg

SIG: Inject _____ SQ every other day
SIG: Other _____
QTY # _____ (1 box = 4 wk supply) Refills: _____

GILENYA 0.5mg (first dose must be taken at the doctor's office)

SIG: Take 1 Capsule by mouth Daily Qty: _____ Refills: _____

LEMTRADA 12mg/1.2mL

SIG: _____ QTY: _____ Refills: _____

OCREVUS 300mg/10 mL

Loading Dose: Infuse 300mg IV on Day 1 followed by 300mg IV 2 weeks later QTY: 2 Vials
Maintenance Dose: Infuse 600mg IV once every 6 months (beginning 6 months after first 300mg dose)
Qty: _____ Refills: _____

REBIF TITRATION PACK 12 syringes

SIG: 8.8mcg SQ TIW - weeks 1 & 2
SIG: 22mcg SQ TIW - weeks 3 & 4 *Maintenance Dose following week 3 & 4*

REBIF 22mcg/0.5ml

SIG: 22mcg (0.5ml) SQ TIW (48hrs apart)
QTY: _____ Refills: _____

REBIF 44mcg/0.5ml (maintenance)

SIG: starting week 5: 44mcg (0.5ml) SQ TIW (48hrs apart)
QTY # _____ Boxes (1 box = 4 week supply) Refills: _____

TECFIDERA 120mg

STARTER Day 1: Take 120mg by mouth BID X 7 days, then 240mg by mouth BID thereafter
MAINTENANCE: 1 Cap (240mg) by mouth BID
Qty: _____ Refills: _____

TYSABRI 300mg IV

SIG: Infuse 300mg IV over 1 hour every 4 weeks
QTY: _____ Refills: _____

OTHER _____

Sig _____ Qty _____ Refills _____

● = Restricted access medication as of November 2013

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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Please fax completed referral form to **Glen Rock Medical Pharmacy** at 201-444-5792 Visit www.GLENROCKMEDICALPHARMACY.com for online fillable forms.