

**MULTIPLE SCLEROSIS REFERRAL FORM**

3070 McCann Farm Drive | Suite 101  
 Garnet Valley, PA 19060

1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

**CURRENT PATIENT**  
 **NEW PATIENT**

June 2017

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**

|  |   |
|--|---|
| <input type="checkbox"/> <b>AUBAGIO</b><br>SIG: <input type="checkbox"/> 7mg: 1 tablet by mouth daily with or without food<br>SIG: <input type="checkbox"/> 14mg: 1 tablet by mouth daily with or without food<br>Qty: _____ Refills: _____  | <input type="checkbox"/> <b>OCREVUS 300mg/10 mL</b><br><b>Loading Dose:</b> Infuse 300mg IV on Day 1 followed by 300mg IV 2 weeks later QTY: 2 Vials<br><b>Maintenance Dose:</b> Infuse 600mg IV once every 6 months (beginning 6 months after first 300mg dose)<br>Qty: _____ Refills: _____ |
| <input type="checkbox"/> <b>AVONEX ADMINISTRATION PACK</b><br><input type="checkbox"/> <b>30mcg PreFilled Syringe</b> <input type="checkbox"/> <b>30mcg Autoinject Pen</b><br>SIG: <input type="checkbox"/> Inject 30mcg IM once weekly<br>SIG: <input type="checkbox"/> Other _____<br>QTY # _____ (1 pack = 4 wk supply) Refills: _____  | <input type="checkbox"/> <b>REBIF TITRATION PACK 12 syringes</b><br>SIG: <input type="checkbox"/> 8.8mcg SQ TIW - weeks 1 & 2<br>SIG: <input type="checkbox"/> 22mcg SQ TIW - weeks 3 & 4 <i>Maintenance Dose following week 3 &amp; 4</i>  |
| <input type="checkbox"/> <b>BETASERON 0.3mg Vials</b><br>SIG: <input type="checkbox"/> Inject _____ SQ every other day<br>SIG: <input type="checkbox"/> Other _____<br>QTY # _____ (1 box = 4 wk supply) Refills: _____  | <input type="checkbox"/> <b>REBIF 22mcg/0.5ml</b><br>SIG: <input type="checkbox"/> 22mcg (0.5ml) SQ TIW (48hrs apart)<br>QTY: _____ Refills: _____  |
| <input type="checkbox"/> <b>COPAXONE</b> <input type="checkbox"/> <b>20mg Syringe</b> <input type="checkbox"/> <b>40mg Syringe</b><br>SIG: <input type="checkbox"/> Inject 20mg SQ once daily<br>SIG: <input type="checkbox"/> Inject 40mg SQ three times a week<br>SIG: <input type="checkbox"/> Other _____<br>QTY: _____ Refills: _____ | <input type="checkbox"/> <b>REBIF 44mcg/0.5ml (maintenance)</b><br>SIG: <input type="checkbox"/> starting week 5: 44mcg (0.5ml) SQ TIW (48hrs apart)<br>QTY # _____ Boxes (1 box = 4 week supply) Refills: _____  |
| <input type="checkbox"/> <b>EXTAVIA VIALS 0.3 mg</b><br>SIG: <input type="checkbox"/> Inject _____ SQ every other day<br>SIG: <input type="checkbox"/> Other _____<br>QTY # _____ (1 box = 4 wk supply) Refills: _____   | <input type="checkbox"/> <b>TECFIDERA 120mg</b><br><b>STARTER</b> Day 1: Take 120mg by mouth BID X 7 days, then 240mg by mouth BID thereafter<br><b>MAINTENANCE:</b> 1 Cap (240mg) by mouth BID<br>QTY: _____ Refills: _____  |
| <input type="checkbox"/> <b>GILENYA 0.5mg</b> (first dose must be taken at the doctor's office)<br>SIG: <input type="checkbox"/> Take 1 Capsule by mouth Daily Qty: _____ Refills: _____   | <input type="checkbox"/> <b>TYSABRI 300mg IV</b><br>SIG: <input type="checkbox"/> Infuse 300mg IV over 1 hour every 4 weeks<br>QTY: _____ Refills: _____  |
| <input type="checkbox"/> <b>LEMTRADA 12mg/1.2mL</b><br>SIG: _____ QTY: _____ Refills: _____  | <input type="checkbox"/> <b>OTHER</b> _____<br>Sig _____ Qty _____ Refills _____  |

 = Restricted access medication as of November 2013

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care and it's 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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