Elwyn SPECIALTY CARE
A BIOMATRIX Company

FEB 2018

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**

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

☐		#	☐		#	☐		#
☐		#	☐		#	☐		#
☐		#	☐		#	☐		#
☐		#	☐		#	☐		#
☐		#	☐		#	☐		#

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 ______

(black label) = 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**______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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