AcariaHealth™
Specialty Pharmacy
Phone: 877.928.5120 • Fax: 877.928.5121

Date Shipment Needed: Click or tap to enter a date. Ship To: ☐Patient ☐Prescriber
☐ Nursing needed; ☐Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

L-Z MULTIPLE SCLEROSIS INJECTABLE AGENTS REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex:☐M ☐F	Weight:	☐lbs. ☐kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐**Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

☐ Multiple Sclerosis ICD-10: G35 Type: ☐ Relapsing remitting ☐ Primary progressive ☐ Secondary progressive ☐ Progressive relapsing ☐ Other: _____

- Has patient been treated previously for this condition? ☐Yes ☐No Previous medication(s): _____
- Is patient currently on therapy? ☐Yes ☐No Current therapy: ☐Aubagio ☐Avonex ☐Bafiertam ☐Betaseron ☐Copaxone ☐Dimethyl Fumarate ☐Extavia ☐Gilenya ☐Glatiramer Acetate ☐Glatopa Kesimpta ☐Lemtrada ☐Mavenclad ☐Mayzent ☐Novantrone ☐Ocrevus ☐Plegridy ☐Ponvory ☐Rebif ☐Tecfidera ☐Tysabri ☐Vumerity ☐Zeposia
- Will patient stop taking the above medication(s) before starting the new medication? ☐Yes ☐No, if yes; How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):_____
- Patient's medical history includes: ☐ Current pregnancy ☐ Congestive heart failure ☐ Severe hepatic impairment ☐ HIV infection ☐ Other: _____

PRESCRIPTION INFORMATION

☐**STC Standard Protocol will include the following: (1) dispensing ordered med/dose, (2) diluent to mix and /or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3mg IM / 0.15mg IM (for pediatric patients) and diphenhydramine 50mg/mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x 1, and diphenhydramine 25mg, may repeat x 1).**

☐ **Lemtrada® 12 mg/0.5 mL** * Patient must be enrolled in Lemtrada REMS. Please fax completed Prescription Ordering form and Lemtrada REMS patient enrollment form to Lemtrada REMS at 1.855.557.2478. Infused at Infusion Centers registered in Lemtrada REMS program. Call 855.676.6326 with questions.

☐ **Ocrevus® 300mg/10mL Single Dose vial** ☐**MD's Office Infusion** ☐**Home Infusion Supplies Required** ☐ **Enroll in Ocrevus Connects™**

- ☐ Starter: 300mg IV on day 1, and day 15 — QTY: _2_ Refills: _0____
- ☐ Maintenance: 600mg IV every 6 months — QTY: _2_ Refills: _____

☐ **Plegridy®** 125 mcg/0.5 mL ☐Plegridy Starter Pack ☐ Pen ☐ Prefilled Syringe ☐ Enroll in Above MS™

- ☐ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15 — QTY: 28 day Refills: 0
- ☐ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days — QTY: 28 day Refills: _____
- ☐ Alternate Dosing: _____ QTY: _____ Refills: _____

☐ **Rebif® 22 mcg/0.5 mL (select dosage form for maintenance doses)** ☐ **Prefilled Syringe** ☐**Rebidose™ Auto Injection** ☐ **Enroll in MS Lifelines™**

- ☐ Dose Titration *(syringes only)* Week 1 & 2: 4.4 mcg (0.1 mL) SQ TIW (48 hours apart), Week 3 & 4: 11 mcg (0.25 mL SQ TIW (48 hours apart) — QTY: 28 day Refills: 0
- ☐ Maintenance Dose: Week 5+: 22 mcg (0.5 mL) SQ TIW (48 hours apart) — QTY: 28 day Refills: _____
- ☐ Alternate Dosing: _____ QTY: _____ Refills: _____

☐ **Rebif® 44 mcg/0.5 mL** ☐ **Prefilled Syringe** ☐ **Rebidose™ Auto Injection** ☐ **Enroll in MS Lifelines™**

- ☐Dose titration: Week 1 & 2: 8.8 mcg (0.2 mL) SQ TIW (48 hours apart), Week 3 & 4: 22 mcg (0.5 mL SQ TIW (48 hours apart) — QTY: 28 day Refills: 0
- ☐ Maintenance Dose: Week 5+: 44 mcg (0.5 mL) SQ TIW (48 hours apart) — QTY: 28 day Refills: _____
- ☐ Alternate Dosing: _____ QTY: _____ Refills: _____

☐ **Tysabri® 300 mg/15 mL** *Please fax Touch Enrollment form directly to TOUCH at 800.840.1278. Infused at Infusion Centers registered in TOUCH program. Patient must be enrolled in TOUCH. Call Biogen with questions 1.800.456.2255

☐ **Other**: QTY: _____ Refills: _____

_____

Physician's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

