

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.

A-K MULTIPLE SCLEROSIS INJECTABLE AGENTS REFERRAL FORM

PATIENT INFORMATION					
Patient Name:			DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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 ASSESSMENT					
<input type="checkbox"/> Multiple Sclerosis ICD-10: G35 Type: <input type="checkbox"/> Relapsing remitting <input type="checkbox"/> Primary progressive <input type="checkbox"/> Secondary progressive <input type="checkbox"/> Progressive relapsing <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Has patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous medication(s): _____					
<input type="checkbox"/> Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Current therapy: <input type="checkbox"/> Aubagio <input type="checkbox"/> Avonex <input type="checkbox"/> Bafiertam <input type="checkbox"/> Betaseron <input type="checkbox"/> Copaxone <input type="checkbox"/> Dimethyl Fumarate <input type="checkbox"/> Extavia <input type="checkbox"/> Gilenya <input type="checkbox"/> Glatiramer Acetate <input type="checkbox"/> Glatopa Kesimpta <input type="checkbox"/> Lemtrada <input type="checkbox"/> Mavenclad <input type="checkbox"/> Mayzent <input type="checkbox"/> Novantrone <input type="checkbox"/> Ocrevus <input type="checkbox"/> Plegridy <input type="checkbox"/> Ponvory <input type="checkbox"/> Rebif <input type="checkbox"/> Tecfidera <input type="checkbox"/> Tysabri <input type="checkbox"/> Vumerity <input type="checkbox"/> Zeposia					
<input type="checkbox"/> Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No, <ul style="list-style-type: none"> <input type="checkbox"/> if yes; How long should patient wait before starting the new medication? _____ 					
<input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
<input type="checkbox"/> Patient's medical history includes: <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Severe hepatic impairment <input type="checkbox"/> HIV infection <input type="checkbox"/> Other: _____					
PRESCRIPTION INFORMATION					
<input type="checkbox"/> 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).					
<input type="checkbox"/> Avonex® 30 mcg					
<input type="checkbox"/> Titration Syringe kit: ¼ dose IM week 1, ½ dose IM week 2, ¾ dose IM week 3, full dose IM week 4				QTY: <u>28 day</u> Refills: <u>0</u>	
<input type="checkbox"/> Pen <input type="checkbox"/> Prefilled syringe <input type="checkbox"/> Maintenance directions: 30mg IM once weekly				QTY: <u>28 day</u> Refills: _____	
<input type="checkbox"/> Alternate dosing: _____				QTY: _____ Refills: _____	
<input type="checkbox"/> Betaseron® <input type="checkbox"/> Betaject Lite® <input type="checkbox"/> BetaConnect® Auto Injection					
<input type="checkbox"/> Dose Titration: Week 1 & 2: 0.0625 mg (0.25 mL) SQ every other day, Week 3 & 4: 0.125 mg (0.5 mL) SQ every other day, Week 5 & 6: 0.875 mg (0.75 mL) SQ every other day, Week 7+: 0.25 mg (1 mL) SQ every other day				<input type="checkbox"/> Enroll in Beta PlusSM MS	
<input type="checkbox"/> Maintenance Dose: 0.25 mg (1 ml) SQ every other day				QTY: <u>28 day</u> Refills: _____	
<input type="checkbox"/> Alternate Dosing: _____				QTY: _____ Refills: _____	
<input type="checkbox"/> Briumvi® <input type="checkbox"/> IMD's Office Infusion <input type="checkbox"/> Home Infusion Supplies Required					
<input type="checkbox"/> Starter dose: 150mg vial, infuse 150mg IV on day 1, then infuse 450mg IV on day 15				QTY: <u>4 vials</u> Refills: <u>0</u>	
<input type="checkbox"/> Maintenance dose: 150mg vial, infuse 450mg IV every 24 weeks				QTY: <u>3 vials</u> Refills: _____	
<input type="checkbox"/> Copaxone® 20 mg/mL PFS OR GENERIC <input type="checkbox"/> Glatiramer Acetate 20 mg/mL PFS					
<input type="checkbox"/> 20mg SQ once daily				<input type="checkbox"/> Enroll in Shared Solutions®	
				QTY: <u>30 day</u> Refills: _____	
<input type="checkbox"/> Copaxone® 40 mg/mL PFS OR GENERIC <input type="checkbox"/> Glatiramer Acetate 40 mg/mL PFS					
<input type="checkbox"/> 40mg SQ three times a week				<input type="checkbox"/> Enroll in Shared Solutions®	
				QTY: <u>28 day</u> Refills: _____	
<input type="checkbox"/> Extavia®					
<input type="checkbox"/> Dose Titration: Week 1 & 2: 0.0625 mg (0.25 mL) SQ every other day, Week 3 & 4: 0.125 mg (0.5 mL) SQ every other day, Week 5 & 6: 0.1875 mg (0.75 mL) SQ every other day, Week 7+: 0.25 mg (1 mL) SQ every other day				<input type="checkbox"/> Enroll in Extavia Go	
<input type="checkbox"/> Maintenance Dose: 0.25 mg (1 mL) SQ every other day				QTY: <u>28 day</u> Refills: <u>1</u>	
Alternate Dosing: _____				QTY: <u>30 day</u> Refills: _____	
				QTY: _____ Refills: _____	
<input type="checkbox"/> Glatopa® 20mg/mL PFS					
<input type="checkbox"/> 20 mg SQ every day				<input type="checkbox"/> Enroll in GlatopaCare™	
<input type="checkbox"/> Alternate Dosing: _____				QTY: <u>30 day</u> Refills: _____	
				QTY: _____ Refills: _____	
<input type="checkbox"/> Glatopa® 40 mg/mL PFS					
<input type="checkbox"/> 40 mg/mL SQ 3 times per week				<input type="checkbox"/> Enroll in GlatopaCare™	
<input type="checkbox"/> Alternate Dosing: _____				QTY: <u>28 day</u> Refills: _____	
				QTY: _____ Refills: _____	
<input type="checkbox"/> Kesimpta® 20mg/0.4mL single-dose <input type="checkbox"/> SensoReady Pen <input type="checkbox"/> Prefilled Syringe					
<input type="checkbox"/> Starter: 20mg SQ once weekly at weeks 0, 1, and 2				<input type="checkbox"/> Enroll in Alongside®	
<input type="checkbox"/> Maintenance: 20mg sq once monthly starting at week 4				QTY: <u>3</u> Refills: <u>0</u>	
				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 the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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