RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Multiple Sclerosis Referral Form

Send your Rx to: (optional)
Select Location

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-Up (store location): _____ Injection training by pharmacy? ☐

1) Patient & Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐lbs. ☐kgs.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA #: _____ NPI #: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Diagnosis/Clinical Information

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Has patient previously been treated for this condition? ○ Yes ○ No Is patient currently on therapy? ○ Yes ○ No
Current Medications: _____
Will patient stop taking the above medication(s) before the new medication? ○ Yes ○ No Diagnosis (ICD-10 code): _____

4) Prescription Information

☐ **Ampyra® (dalfampridine)** brand ☐ **Ampyra® (dalfampridine)** generic
MD Specialty: ☐ Neurology ☐ Other: _____
Diagnosis: ☐ MS ☐ Other: _____
Age (18 or older): ○ Yes ○ No
Current or PMH: ☐ CKD ☐ AKI ☐ Seizure
Current Medication List Including OTC: Cimetidine ○ Yes ○ No
Allergy to Dalfampridine (4-aminopyridine): ○ Yes ○ No
Pregnant: ○ Yes ○ No Breastfeeding: ○ Yes ○ No
Lab Results: ☐ CrCl _____ ml/min ☐ Scr _____ mg/dl
Baseline T25FW: _____ seconds Date completed: _____
EDSS Score: _____
Sig: ☐ 10 mg ER PO every 12 hours. Number of Refills: _____

☐ **Avonex® (interferon beta-1a)** ☐30mcg/vial kit ☐Prefilled 30mcg/0.5mL
Sig: ☐ 30mcg intramuscularly (IM) once a week
Once-weekly dosing with 7.5mcg IM (week 1), then increase dose in increments of 7.5mcg IM once weekly (weeks 2 to 4) up to recommended dose (30mcg IM once weekly).
Duration: _____

☐ **Betaseron® (interferon beta-1b)** 0.3mg kit
Sig: ☐ 0.0625mg SC every other day ☐ 0.25mg SC every other day
Duration: _____

☐ **Copaxone® (glatiramer acetate)** 20mg/mL solution prefilled syringe
☐ **Copaxone® (glatiramer acetate)** 40mg/mL solution prefilled syringe
Sig: ☐ 20mg/mL subcutaneously once daily
☐ 40mg/mL 3 times per week (**Copaxone®** only) administered at least 48 hours apart.
Duration: _____

☐ **Extavia® (interferon beta-1b)** 0.3mg kit

☐ **Ocrevus® (ocrelizumab)**
Sig: 300mg IV on day 1, followed by 300mg IV 2 weeks later; subsequent doses of 600mg IV are administered once every 6 months (beginning 6 months after the first 300mg dose).

☐ **Plegridy® (peginterferon beta-1a)** 125mcg/0.5mL solution pen-injector
☐ **Plegridy® (peginterferon beta-1a)** 125mcg/0.5mL solution prefilled syringe
☐ **Plegridy® (peginterferon beta-1a)** Starter Pack** solution pen-injector
☐ **Plegridy® (peginterferon beta-1a)** Starter Pack** solution prefilled syringe
Sig: 63mcg subcutaneously on day 1; 94mcg subcutaneously on day 15; 125mcg subcutaneously on day 29 and every 14 days thereafter.
Maintenance Dose: 125mcg subcutaneously every 14 days.
Duration: _____

☐ **Rebif® (interferon beta-1a)** 22mcg/0.5mL solution prefilled syringe
☐ **Rebif® (interferon beta-1a)** 44mcg/0.5mL solution prefilled syringe
☐ **Rebif® (interferon beta-1a)** Rebidose 22mcg/0.5mL solution auto-injector
☐ **Rebif® (interferon beta-1a)** Rebidose 44mcg/0.5mL solution auto-injector
☐ **Rebif® (interferon beta-1a)** Rebidose Titration Pack** solution auto-injector
☐ **Rebif Titration Pack** solution prefilled syringe**
Sig: _____ mcg SC 3 times per week. Duration: _____

5) Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

#of Prescriptions

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.