



# MORRISTOWN PHARMACY

## MULTIPLE SCLEROSIS REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960

Tel: 973 - 998 - 0287 | Fax: 973 - 998 - 0288

Today's Date

Anticipated Start Date

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

NEW PATIENT  CURRENT PATIENT

Last updated: May 2017

Patient Name First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ DOB \_\_\_\_\_ Weight \_\_\_\_\_  Male  Female

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Tel \_\_\_\_\_ Evening Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Ship to Patient at  Home  Work **OR** Patient will pick up at  Physician Office  Pharmacy Date Needed \_\_\_\_\_

ICD-10 Diagnosis Code  G35 Multiple Sclerosis **OR** Other \_\_\_\_\_ Allergies \_\_\_\_\_

Patient currently on therapy  Yes  No Date of next blood work \_\_\_\_\_ Comments \_\_\_\_\_

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# \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Office Contact \_\_\_\_\_

Street Address \_\_\_\_\_ Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

License# \_\_\_\_\_ NPI# \_\_\_\_\_ UPIN# \_\_\_\_\_ DEA# \_\_\_\_\_

### PRESCRIPTION

### PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

#### AVONEX ADMINISTRATION PACK 30mcg PreFilled

SIG  Inject 30mcg IM once weekly  Other \_\_\_\_\_

QTY # \_\_\_\_\_ Weeks (1 pack = 4 week supply) Refills x \_\_\_\_\_

#### BETASERON 0.3mg Vials

SIG  Inject \_\_\_\_\_ SC every other day  Other \_\_\_\_\_

QTY # \_\_\_\_\_ Weeks (1 box = 4 week supply) Refills x \_\_\_\_\_

#### COPAXONE

##### 40mg/ml Syringe

SIG  Inject 40mg SC three times weekly

Other \_\_\_\_\_

##### 20mg/ml Syringe

SIG  Inject 20mg SC once daily  Other \_\_\_\_\_

QTY # \_\_\_\_\_ Syringes Refills x \_\_\_\_\_

#### EXTAVIA VIALS

SIG  Inject \_\_\_\_\_ SC every other day  Other \_\_\_\_\_

QTY # \_\_\_\_\_ Weeks (1 box = 4 week supply) Refills x \_\_\_\_\_

#### REBIF TITRATION PACK 12 syringes

SIG  8.8mcg SQ TIW - weeks 1 & 2  22mcg SQ TIW - weeks 3 & 4

Maintenance Dose following week 3 & 4

QTY # \_\_\_\_\_ Boxes (1 box = 4 week supply) Refills x \_\_\_\_\_

#### REBIF 22mcg/0.5ml

SIG  22mg (0.5ml) SQ TIW (48hrs apart)

QTY # \_\_\_\_\_ Boxes (1 box = 4 week supply) Refills x \_\_\_\_\_

#### REBIF 44mcg/0.5ml (maintenance)

SIG  starting week 5: 44mcg (0.5ml) SQ TIW (48hrs apart)

QTY # \_\_\_\_\_ Boxes (1 box = 4 week supply) Refills x \_\_\_\_\_

#### OTHER

SIG \_\_\_\_\_ QTY \_\_\_\_\_ Refills x \_\_\_\_\_

SIG \_\_\_\_\_ QTY \_\_\_\_\_ Refills x \_\_\_\_\_

**GILENYA** 0.5 mg \_\_\_\_\_ orally once daily QTY - 28 Refill X \_\_\_\_\_

**ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) \_\_\_\_\_ Date \_\_\_\_\_

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Please fax completed form to **Morristown Pharmacy** at **973 - 998 - 0288**

Visit us at **WWW.MORRISTOWNRX.COM** for online fillable forms.