MORRISTOWN PHARMACY

MULTIPLE SCLEROSIS REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960
Tel : 973 - 998 - 0287 | Fax : 973 - 998 - 0288

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

Today's Date | Anticipated Start Date

☐ 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

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**

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

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