SPECIALTY CARE SOLUTIONS

Multiple Sclerosis ℞ Referral Form
Self-Injectable

3712 Park Ave. Weehawken, NJ 07086
Phone: (201)552-9500 Fax:(888)332-4494
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E-Scripts NCPDP#3199367 NPI#1881932093

Date Medication Needed: ____________ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Or Pick-up from Pharmacy

Injection needed by pharmacy? ☐ Yes ☐ No

1: Patient Information

Patient Name: ______________ Birthdate: ________ Sex: Male Female Height: ______ Weight: ______ lbs. kg.

Soc. Sec. #: ______________ Preferred Phone: ______________ Known Allergies: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Alternate Caregiver Name: ______________ Preferred Phone: ______________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ ______________ Diagnosis Date: ______________

Type: ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Secondary-progressive ☐ Primary-progressive ☐ Progressive-relapsing

Hepatic Impairment present: ☐ Yes ☐ No ☐ Ast: ________ U/L ALT: ________ U/L Bilirubin: ________ mg/dL Lab date: ________

Pre-existing hepatic conditions: ☐ HBV ☐ HCV ☐ ______________ TB Test: ☐ Positive ☐ Negative Test Date: ________

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: ______________

Concomitant Medications: ______________

Allergies: ☐ NKDA ☐ Other: ______________

3: Prescriber Information

Prescriber Name: ______________ DEA#: ________ NPI#: ________ Tax ID#: ________

Address: ______________ Phone: (_____) ______ - ______ Fax: (_____) ______ - ______

City: ______________ State: ______ Zip: ______ Key Contact: ______________ Phone: (_____) ______ - ______

4: Prescription Information

§ Avonex®, Betaseron®, Copaxone® are available on the Multiple Sclerosis - Self-InjectableAgents Enrollment Form A-D §

Medication	Directions	Quantity		Refill
☐ **Extavia® (interferon beta-1a)**	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	☐ 15 x 0.3 mg	Vials	0
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-on ward: Inject 0.25 mg (1 mL) subcut every other day.	☐ 15 x 0.3 mg	Vials	0
	☐ Inject 0.25 mg (1 mL) subcut every other)	☐ 15 x 0.3 mg	Vials	______
☐ **Betaseron® (interferon beta-1b)**	☐ Week 1-2: Inject 4.4 mg (0.1 mL) subcut three times per week; ☐ Week 3-4: Inject 11 mg (0.25 mL) subcut three times per week.	☐ 6 x 8.8 mcg 6 x 22 mcg	PFS	0
	☐ Week 5 and thereafter: Inject 22 mcg subcut three times per week	☐ 12 x 22 mcg	☐ Autoinjectors ☐ PFS	______
	☐ Week 1-2: Inject 8.8 mg (0.2 mL) subcut three times per week; ☐ Week 3-4: Inject 22 mg (0.5 mL) subcut three times per week.	☐ 6 x 8.8 mcg 6 x 22 mcg	☐ Autoinjectors ☐ PFS	0
	☐ Week 5 and thereafter: Inject 44 mcg subcut three times per week	☐ 12 x 44 mcg	☐ Autoinjectors ☐ PFS	______
☐ **Plegridy® (peginterferon beta-1a)**	☐ Inject 63 mcg subcut on day 1; then inject 94 mcg on day 15	☐ 1 x 63 mcg ☐ 1 x 94 mcg	☐ Pens ☐ PFS	0
	☐ Inject 125 mcg subcut on day 29 and every two weeks thereafter	☐ 2 x 125 mcg	☐ Pens ☐ PFS	______
☐ **Zinbryta™ (daclizumab)**	To order, please see the Zinbryta™ forms at https://www.zinbrytarems.com/			

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: ______________

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: ______________ Date: ______________

I authorize Park Ave. Pharmacy and its representatives to act as an agent to execute Prior authorization process.

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissable ______________ Date ______ Dispense as written ______________ Date ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.