MULTIPLE SCLEROSIS REFERRAL FORM

Jersey Shore Pharmacy

580 N. Main Street • Barnegat, NJ 08005
Toll Free Phone: 844-422-7959 • Toll Free Fax: 844-360-9788

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name_____ Date of Birth_____
☐ Male ☐ Female SS#_____ Language_____
Address_____ Apt #_____
City_____ State_____ ZIP_____
Phone_____ Cell_____ Email_____
Allergies_____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

Insured's Name_____
Relation to Patient_____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare#_____
Prescription Card ☐ Yes ☐ No If Yes, Carrier_____
Phone_____ Fax_____
Policy/Group#_____
Bin#_____ Pcn#_____
RXID#_____ RX Group#_____

ICD-10 Code: ☐ G35 Multiple Sclerosis OR ☐ Other_____
Type: ☐ Relapsing-remitting ☐ Primary progressive ☐ Secondary progressive ☐ Progressing Relapsing ☐ Other Diagnosis _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the med(s) before starting the new medication? ☐ Yes ☐ No If yes, how long should patient wait before starting the new medication? _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AUBAGIO ☐ 7mg ☐ 14mg QTY:_____ Refill:_____
SIG: 1 tablet PO daily with or without food

AVONEX ADMINISTRATION PACK **30mcg PreFilled**
SIG: ☐ Inject 30mcg IM once weekly
☐ Other _____
QTY: #_____ Weeks *(1 pack = 4 wk supply)* Refill:_____

BETASERON **0.3mg Vials**
SIG: ☐ Inject _____ SC every other day
☐ Other _____
QTY: #_____ Weeks (1 box = 4 wk supply) Refill:_____

COPAXONE ☐ **20mg/ml Syringe** ☐ **40mg/ml Syringe**
SIG: ☐ Inject 20mg (2ml) SQ once daily
☐ Inject 40mg SQ three times weekly
☐ Other _____
QTY: #_____ Syringes Refill:_____

GILENYA **0.5mg** (first dose must be taken at the doctor's office)
SIG: ☐ Take 1 Capsule PO Daily QTY:_____ Refill:_____

EXTAVIA VIALS
SIG: ☐ Inject _____ SQ every other day
☐ Other _____
QTY: #_____ Weeks (1 box = 4 wk supply) Refill:_____

PLEGRIDY
☐ Starter PFS ☐ Starter Pen ☐ 125 mcg PFS ☐ 125 mcg Pen
☐ **Starting Dose:** ☐ Inject 63 mcg SQ on day 1, 94 mcg on day 15, then 125 mcg every 14 days thereafter
☐ **Maintenance:** Inject 125 mcg SQ every 14 days
QTY: #_____ Syringes Refill:_____

GLATOPA **20 mg/mL PreFilled Syringe**
SIG: ☐ Inject 20 mg/mL in a single-dose PFS once per day
QTY: #_____ Syringes Refill:_____

OCREVUS **300 mg/10 mL Single-dose Vial**
☐ Start dose: 300 mg IV infusion, followed two weeks later by a second 300 mg IV infusion
☐ Maint Doses: 600 mg IV infusion every 6 months
QTY: #_____ Vials Refill:_____

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

REBIF **22mcg/0.5ml**
SIG: ☐ 22mg (0.5ml) SQ TIW (48hrs apart)

REBIF **44mcg/0.5ml (maintenance)**
SIG: ☐ starting week 5: 44mcg (0.5ml) SQ TIW (48hrs apart)
QTY: #_____ Boxes (1 box = 4 week supply) Refill:_____

TECFIDERA **120mg**
☐ **Starting Dose:** Day 1: Take 120mg PO BID X 7D then 240mg PO BID thereafter
☐ **Maintenance:** 1 Cap (240mg) PO BID
QTY:_____ Refill:_____

TYSABRI **300mg IV**
SIG: ☐ Infuse 300mg IV over 1 hour every 4 weeks

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ ZIP_____
Phone_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

Prescriber's Signature (signature required. NO STAMPS) _____ **Date**_____

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed form to **JERSEY SHORE PHARMACY** at **844-360-9788** Visit us at **WWW.JERSEYSHOREPHARMACYBARNEGAT.COM** for online fillable forms.