



# STAR CARE PHARMACY

"The First Wealth is Health"

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# MULTIPLE SCLEROSIS REFERRAL FORM

Date: \_\_\_\_\_ Attn: \_\_\_\_\_

Ship to  Patient  Physician Office  Nurse/Training

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_ Suite# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Tel \_\_\_\_\_ Work Tel \_\_\_\_\_  
 Cell \_\_\_\_\_ Email \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 Male  Female Weight \_\_\_\_\_ Height \_\_\_\_\_

Prescriber's Name \_\_\_\_\_  
 License# \_\_\_\_\_ DEA# \_\_\_\_\_  
 NPI# \_\_\_\_\_ UPIN# \_\_\_\_\_  
 Practice Name \_\_\_\_\_  
 Office Contact \_\_\_\_\_  
 Address \_\_\_\_\_ Suite# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Tel \_\_\_\_\_ Fax \_\_\_\_\_

### Insurance Information (Complete or attach copies of cards)

Primary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
 ID#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

### Diagnostic & Clinical Information

ICD-10 Diagnosis Code:  G35 Multiple Sclerosis OR  Other Diagnosis \_\_\_\_\_  
 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 medication(s) before starting the new medication?  Yes  No  
 If yes, how long should patient wait before starting the new medication? \_\_\_\_\_  
 Current medications patient (including OTC) with dosage and direction (or fax medication) \_\_\_\_\_

### Prescription

**AVONEX** PreFilled Syringe  **AVONEX** vial  
 SIG: Inject 30mcg IM once weekly  Enroll in MS ActiveSource  
 Other \_\_\_\_\_ QTY: 28 Day Supply Refill \_\_\_\_\_

**BETASERON**  **BETAJECT LITE**  Enroll in Beta Plus MS  
 Week 1 & 2: 0.0625 mg (0.25 ml) SQ every other day  
 Week 3 & 4: 0.125 mg (0.5 ml) SQ every other day  
 Week 5 & 6: 0.1875 mg (0.75 ml) SQ every other day  
 Week 7+: 0.25 mg (1 ml) SQ every other day  
 Maintenance Dose: 0.25 mg (1ml) SQ every other day  
 Other \_\_\_\_\_ QTY: 28 Day Supply Refill \_\_\_\_\_

**EXTAVIA**  Dose Titration  Enroll in Extavia Program  
 Week 1 & 2: 0.0625 mg (0.25 ml) SQ every other day  
 Week 3 & 4: 0.125 mg (0.5 ml) SQ every other day  
 Week 5 & 6: 0.1875 mg (0.75 ml) SQ every other day  
 Week 7+: 0.25 mg (1 ml) SQ every other day  
 Maintenance Dose 0.25 mg (1ml) SQ every other day  
 Other \_\_\_\_\_ QTY: 30 Day Supply Refill \_\_\_\_\_

**COPAXONE**  **COPAXONE AUTOJECT**  
 20 mg. SQ every day  Enroll in Shared Solutions  
 Other \_\_\_\_\_ QTY: 30 Day Supply Refill \_\_\_\_\_

**AMPYRA** 10 mg Extended Release Tablets  
 Other \_\_\_\_\_ Qty: 30 Day Supply Refill \_\_\_\_\_

**REBIF** 22 mcg/0.5ml  **REBIJECT** Auto Injection  
 Dose Titration  Enroll in MS Lifelines  
 Week 1 & 2: 4.4 mcg (0.1 ml) SQ TIW (48 hours apart);  
 Week 3 & 4: 11 mcg (0.25 ml) SQ TIW (48 hours apart)  
 Maintenance Dose: Week 5+: 22 mcg (0.5 ml) SQ TIW (48 hrs apart)  
 Other \_\_\_\_\_ QTY: 28 Day Supply Refill \_\_\_\_\_  
 (No refills on starting does unless it is specified by Physician)

**REBIF** 44 mcg/0.5ml  **REBIJECT** Auto Injection  
 Dose Titration (Rebif Titration Pack) Note: Will dispense  
 Rebif Titration Pack for Dose Titration only for the first month (No Refill)  
 Week 1 & 2: 8.8 mcg (0.2 ml) SQ TIW (48 hours apart)  
 Week 3 & 4: 22 mcg (0.5 ml) SQ TIW (48 hours apart)  
 Maintenance Dose:  **REBIF** 44 mcg/0.5ml  
 Week 5+: 44 mcg (0.5 ml) SQ TIW (48 hours apart)  
 Other \_\_\_\_\_ QTY: 28 Day Supply Refill \_\_\_\_\_  
 (No refill for Rebif Titration Pack)  Enroll in MS Lifelines

**GILENYAL** 0.5mg Capsule  1 capsule orally once daily  
 Other \_\_\_\_\_ QTY: 28 Day Supply Refill \_\_\_\_\_

**TYSABRI** 300 mg/15 ml (Patient must be enrolled in TOUCH program)  
 Dosage: 300 mg (in 100 ml NS) IV infusion over 1 hr every 4 wks  
 Other \_\_\_\_\_ QTY: 1 vial Refill \_\_\_\_\_

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

IMPORTANT NOTICE: This Facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.