QUICK RX SPECIALTY PHARMACY
tel: 800-496-6111

MULTIPLE SCLEROSIS REFERRAL FORM

FAX:800-540-1852

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

June 2017

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

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# _____

ICD-10 Diagnosis Code ☐ G35 Multiple Sclerosis OR ☐ Other_____ Patient Weight_____
Patient currently on therapy ☐ Yes ☐ No Date of next blood work_____
Comments_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AUBAGIO**
SIG: ☐ 7mg: 1 tablet by mouth daily with or without food
SIG: ☐ 14mg: 1 tablet by mouth daily with or without food
Qty:_____ Refills: _____

AVONEX ADMINISTRATION PACK
☐ 30mcg PreFilled Syringe ☐ 30mcg Autoinject Pen
SIG: ☐ Inject 30mcg IM once weekly
SIG: ☐ Other _____
QTY # _____ (1 pack = 4 wk supply) Refills: _____

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

COPAXONE ☐ 20mg Syringe ☐ 40mg Syringe
SIG: ☐ Inject 20mg SQ once daily
SIG: ☐ Inject 40mg SQ three times a week
SIG: ☐ Other _____
QTY:_____ Refills: _____

☐ **EXTAVIA VIALS 0.3 mg**
SIG: ☐ Inject _____ SQ every other day
SIG: ☐ Other _____
QTY # _____ (1 box = 4 wk supply) Refills: _____

☐ **GILENYA 0.5mg** *(first dose must be taken at the doctor's office)*
SIG: ☐ Take 1 Capsule by mouth Daily Qty:_____ Refills: _____

☐ **LEMTRADA 12mg/1.2mL**
SIG: _____QTY:_____ Refills: _____

☐ **OCREVUS 300mg/10 mL**
Loading Dose: Infuse 300mg IV on Day 1 followed by 300mg IV 2 weeks later QTY: 2 Vials
Maintenance Dose: Infuse 600mg IV once every 6 months (beginning 6 months after first 300mg dose)
Qty:_____ Refills: _____

REBIF TITRATION PACK 12 syringes
SIG: ☐ 8.8mcg SQ TIW - weeks 1 & 2
SIG: ☐ 22mcg SQ TIW - weeks 3 & 4 *Maintenance Dose following week 3 & 4*

REBIF 22mcg/0.5ml
SIG: ☐ 22mcg (0.5ml) SQ TIW (48hrs apart)
QTY:_____ Refills: _____

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

☐ **TECFIDERA 120mg**
STARTER Day 1: Take 120mg by mouth BID X 7 days, then 240mg by mouth BID thereafter
MAINTENANCE: 1 Cap (240mg) by mouth BID
Qty:_____ Refills: _____

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

OTHER _____
Sig _____Qty _____ Refills _____

▬ = Restricted access medication as of November 2013

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

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

Provider please fax completed referral form to **QuickRx Specialty Pharmacy** at **800-540-1852** Visit **www.QuickRxSpecialty.com** for online fillable forms.