Date Shipment Needed: Click or tap to enter a date. Ship To: ☐Patient ☐Prescriber
☐ Nursing needed; ☐Training needed ► All the supplies including syringes and needles will be dispensed if needed.

Phone: 877.928.5120 • Fax: 877.928.5121

A-K MULTIPLE SCLEROSIS INJECTABLE AGENTS REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex:☐M ☐F	Weight:	☐lbs. ☐kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐**Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

☐ Multiple Sclerosis ICD-10: G35 Type: ☐ Relapsing remitting ☐ Primary progressive ☐ Secondary progressive ☐ Progressive relapsing ☐ Other: _____

- Has patient been treated previously for this condition? ☐Yes ☐No Previous medication(s): _____
- Is patient currently on therapy? ☐Yes ☐No Current therapy: ☐Aubagio ☐Avonex ☐Bafiertam ☐Betaseron ☐Copaxone ☐Dimethyl Fumarate ☐Extavia ☐Gilenya ☐Glatiramer Acetate ☐Glatopa Kesimpta ☐Lemtrada ☐Mavenclad ☐Mayzent ☐Novantrone ☐Ocrevus ☐Plegridy ☐Ponvory ☐Rebif ☐Tecfidera ☐Tysabri ☐Vumerity ☐Zeposia
- Will patient stop taking the above medication(s) before starting the new medication? ☐Yes ☐No,
  - if yes; How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):_____
- Patient's medical history includes: ☐ Current pregnancy ☐ Congestive heart failure ☐ Severe hepatic impairment ☐ HIV infection ☐ Other: _____

PRESCRIPTION INFORMATION

☐STC Standard Protocol will include the following: (1) dispensing ordered med/dose, (2) diluent to mix and /or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3mg IM / 0.15mg IM (for pediatric patients) and diphenhydramine 50mg/mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x 1, and diphenhydramine 25mg, may repeat x 1).

☐Avonex® 30 mcg
☐Titration Syringe kit: ¼ dose IM week 1, ½ dose IM week 2, ¾ dose IM week 3, full dose IM week 4 — QTY: 28 day Refills: 0
☐ Pen ☐ Prefilled syringe ☐ Maintenance directions: 30mg IM once weekly — QTY: 28 day Refills: ____
☐Alternate dosing _____ — QTY: ____ Refills: ____

☐ Betaseron® ☐ Betaject Lite® ☐ BetaConnect® Auto Injection — **☐ Enroll in Beta PlusSM MS**
☐Dose Titration: 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: 0.875 mg (0.75 mL) SQ every other day, Week 7+: 0.25 mg (1 mL) SQ every other day — QTY: 28 day Refills: 1
☐ Maintenance Dose: 0.25 mg (1 ml) SQ every other day — QTY: 28 day Refills: ____
☐ Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ Briumvi® ☐MD's Office Infusion ☐Home Infusion Supplies Required
☐Starter dose: 150mg vial, infuse 150mg IV on day 1, then infuse 450mg IV on day 15 — QTY: 4 vials Refills: 0
☐Maintenance dose: 150mg vial, infuse 450mg IV every 24 weeks — QTY: 3 vials Refills: ____

☐ Copaxone® 20 mg/mL PFS OR GENERIC ☐ Glatiramer Acetate 20 mg/mL PFS — **☐ Enroll in Shared Solutions®**
☐20mg SQ once daily — QTY: 30 day Refills: ____

☐ Copaxone® 40 mg/mL PFS OR GENERIC ☐ Glatiramer Acetate 40 mg/mL PFS — **☐ Enroll in Shared Solutions®**
☐40mg SQ three times a week — QTY: 28 day Refills: ____

☐ Extavia® — **☐ Enroll in Extavia Go**
☐ Dose Titration: 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 — QTY: 28 day Refills: 1
☐ Maintenance Dose: 0.25 mg (1 mL) SQ every other day — QTY: 30 day Refills: ____
Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ Glatopa® 20mg/mL PFS — **☐ Enroll in GlatopaCare™**
☐ 20 mg SQ every day — QTY: 30 day Refills: ____
☐ Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ Glatopa ® 40 mg/mL PFS — **☐ Enroll in GlatopaCare™**
☐ 40 mg/mL SQ 3 times per week — QTY: 28 day Refills: ____
☐ Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ **Kesimpta®** 20mg/0.4mL single-dose ☐ SensoReady Pen ☐ Prefilled Syringe — **☐ Enroll in Alongside®**
☐ Starter: 20mg SQ once weekly at weeks 0, 1, and 2 — QTY: 3 Refills: 0
☐ Maintenance: 20mg sq once monthly starting at week 4 — QTY: ____ Refills: ____

Physician's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.