

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

### L-Z MULTIPLE SCLEROSIS INJECTABLE AGENTS REFERRAL FORM

PATIENT INFORMATION					
Patient Name:			DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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 ASSESSMENT					
<input type="checkbox"/> Multiple Sclerosis ICD-10: G35 Type: <input type="checkbox"/> Relapsing remitting <input type="checkbox"/> Primary progressive <input type="checkbox"/> Secondary progressive <input type="checkbox"/> Progressive relapsing <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Has patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous medication(s): _____					
<input type="checkbox"/> Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Current therapy: <input type="checkbox"/> Aubagio <input type="checkbox"/> Avonex <input type="checkbox"/> Bafiertam <input type="checkbox"/> Betaseron <input type="checkbox"/> Copaxone <input type="checkbox"/> Dimethyl Fumarate <input type="checkbox"/> Extavia <input type="checkbox"/> Gilenya <input type="checkbox"/> Glatiramer Acetate <input type="checkbox"/> Glatopa Kesimpta <input type="checkbox"/> Lemtrada <input type="checkbox"/> Mavenclad <input type="checkbox"/> Mayzent <input type="checkbox"/> Novantrone <input type="checkbox"/> Ocrevus <input type="checkbox"/> Plegridy <input type="checkbox"/> Ponvory <input type="checkbox"/> Rebif <input type="checkbox"/> Tecfidera <input type="checkbox"/> Tysabri <input type="checkbox"/> Vumerity <input type="checkbox"/> Zeposia					
<input type="checkbox"/> Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No, if yes; How long should patient wait before starting the new medication? _____					
<input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
<input type="checkbox"/> Patient's medical history includes: <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Severe hepatic impairment <input type="checkbox"/> HIV infection <input type="checkbox"/> Other: _____					
PRESCRIPTION INFORMATION					
<input type="checkbox"/> <b>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).</b>					
<input type="checkbox"/> <b>Lemtrada® 12 mg/0.5 mL</b> * Patient must be enrolled in Lemtrada REMS. Please fax completed Prescription Ordering form and Lemtrada REMS patient enrollment form to Lemtrada REMS at 1.855.557.2478. Infused at Infusion Centers registered in Lemtrada REMS program. Call 855.676.6326 with questions.					
<input type="checkbox"/> <b>Ocrevus® 300mg/10mL Single Dose vial</b>		<input type="checkbox"/> MD's Office Infusion		<input type="checkbox"/> Home Infusion Supplies Required	
<input type="checkbox"/> Starter: 300mg IV on day 1, and day 15				<input type="checkbox"/> <b>Enroll in Ocrevus Connects™</b> QTY: <u>  2  </u> Refills: <u>  0  </u>	
<input type="checkbox"/> Maintenance: 600mg IV every 6 months				QTY: <u>  2  </u> Refills: _____	
<input type="checkbox"/> <b>Plegridy® 125 mcg/0.5 mL</b>		<input type="checkbox"/> Plegridy Starter Pack		<input type="checkbox"/> Pen	
<input type="checkbox"/> Prefilled Syringe				<input type="checkbox"/> Enroll in Above MS™ QTY: <u>  28  </u> day Refills: <u>  0  </u>	
<input type="checkbox"/> Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15				QTY: <u>  28  </u> day Refills: _____	
<input type="checkbox"/> Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days				QTY: _____ Refills: _____	
<input type="checkbox"/> Alternate Dosing: _____					
<input type="checkbox"/> <b>Rebif® 22 mcg/0.5 mL (select dosage form for maintenance doses)</b>		<input type="checkbox"/> Prefilled Syringe		<input type="checkbox"/> Rebidose™ Auto Injection	
<input type="checkbox"/> Dose Titration ( <i>syringes only</i> ) 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)				<input type="checkbox"/> <b>Enroll in MS Lifelines™</b> QTY: <u>  28  </u> day Refills: <u>  0  </u>	
<input type="checkbox"/> Maintenance Dose: Week 5+: 22 mcg (0.5 mL) SQ TIW (48 hours apart)				QTY: <u>  28  </u> day Refills: _____	
<input type="checkbox"/> Alternate Dosing: _____				QTY: _____ Refills: _____	
<input type="checkbox"/> <b>Rebif® 44 mcg/0.5 mL</b>		<input type="checkbox"/> Prefilled Syringe		<input type="checkbox"/> Rebidose™ Auto Injection	
<input type="checkbox"/> Dose titration: 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)				<input type="checkbox"/> <b>Enroll in MS Lifelines™</b> QTY: <u>  28  </u> day Refills: <u>  0  </u>	
<input type="checkbox"/> Maintenance Dose: Week 5+: 44 mcg (0.5 mL) SQ TIW (48 hours apart)				QTY: <u>  28  </u> day Refills: _____	
<input type="checkbox"/> Alternate Dosing: _____				QTY: _____ Refills: _____	
<input type="checkbox"/> <b>Tysabri® 300 mg/15 mL</b> *Please fax Touch Enrollment form directly to TOUCH at 800.840.1278. Infused at Infusion Centers registered in TOUCH program. Patient must be enrolled in TOUCH. Call Biogen with questions 1.800.456.2255					
<input type="checkbox"/> <b>Other:</b> _____				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.

**IMPORTANT NOTICE:** This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet. Rev 20230310