

MULTIPLE SCLEROSIS ORAL 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 <input type="checkbox"/> 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"/> Aubagio® 7 mg tablet <input type="checkbox"/> Aubagio® 14 mg tablet <input type="checkbox"/> take one tablet PO Once daily <input type="checkbox"/> Alternate Dose: _____		<input type="checkbox"/> Enroll in MS One to One® Program QTY: <u>30 day supply</u> Refills: _____			
<input type="checkbox"/> Bafiertam® 95mg capsule <input type="checkbox"/> take one 95mg capsule PO twice a day for 7 days. Starting on Day 8, take 190mg (2x95mg caps) PO twice a day <input type="checkbox"/> Alternate Dose: _____		QTY: <u>30 day supply</u> Refills: _____ QTY: <u>30 day supply</u> Refills: _____			
<input type="checkbox"/> Cortrophin Gel 5mL vials containing 80 USP units/mL Directions: _____		<input type="checkbox"/> Enroll in Cortrophin in your Corner™ QTY: _____ Refills: _____			
<input type="checkbox"/> Dalfampridine EXTENDED RELEASE 10 mg tablet <input type="checkbox"/> take one tablet PO BID (12 hours apart) <input type="checkbox"/> take one tablet PO once daily <input type="checkbox"/> Alternate Dose: _____		QTY: <u>30 day supply</u> Refills: _____ QTY: <u>1 kit</u> Refills: <u>0</u>			
<input type="checkbox"/> Dimethyl Fumarate Starter Pack 14x120mg & 46x240mg Take one 120mg capsule PO BID for 7 days, then take 240mg PO BID x 23 days		QTY: <u>14 capsules</u> Refills: _____ QTY: <u>60 capsules</u> Refills: _____			
<input type="checkbox"/> Dimethyl Fumarate 120 mg capsules PO BID					
<input type="checkbox"/> Dimethyl Fumarate 240 mg capsules PO BID					
<input type="checkbox"/> Fingolimod 0.5 mg Capsule <input type="checkbox"/> 1 capsule orally once daily <input type="checkbox"/> Alternate Dose: _____		QTY: <u>28 day supply</u> Refills: _____			
<input type="checkbox"/> Gilenya® 0.5 mg Capsule <input type="checkbox"/> 1 capsule orally once daily <input type="checkbox"/> Alternate Dose: _____		<input type="checkbox"/> Enroll in Gilenya Go Program™ QTY: <u>28 day supply</u> Refills: _____			
<input type="checkbox"/> Tecfidera® 30-day Starter Pack (120/240 mg) Note: Will dispense for the first month only (no refill) Take 120 mg PO BID for 7 days, then 240 mg PO BID for 23 days		<input type="checkbox"/> Enroll in MS™ QTY: <u>30 day supply</u> Refills: _____ QTY: <u>30 day supply</u> Refills: _____ QTY: <u>7 day supply</u> Refills: _____			
<input type="checkbox"/> Tecfidera® Maintenance Dose: Tecfidera (240 mg): Take 240 mg PO BID					
<input type="checkbox"/> Tecfidera® Dose Modification: Tecfidera (120 mg): Take 120 mg PO BID					
<input type="checkbox"/> Teriflunomide® 7 mg tablet <input type="checkbox"/> Teriflunomide® 14 mg tablet <input type="checkbox"/> take one tablet PO Once daily <input type="checkbox"/> Alternate Dose: _____		QTY: <u>30 day supply</u> Refills: _____ QTY: <u>14 day supply</u> Refills: <u>0</u> QTY: <u>30 tablets</u> Refills: _____			
<input type="checkbox"/> Ponvory® Starter Kit Use as directed for initial 14 day dosage titration					
<input type="checkbox"/> Ponvory® 20 mg tablet take 1 tablet PO once daily (beginning on day 15)					
<input type="checkbox"/> Vumerity® 231 mg capsules <input type="checkbox"/> Initial: 1 capsule (231mg) by mouth BID for 7 days, then increase to 2 capsules (462mg) by mouth BID thereafter <input type="checkbox"/> Maintenance: 2 capsules (462mg) by mouth BID		QTY: <u>106</u> Refills: <u>0</u> QTY: <u>120</u> Refills: _____			
<input type="checkbox"/> Zeposia® Titration Starter Kit 0.23mg po once daily on days 1-4, then 0.46mg po once daily on days 5-7, then start 0.92mg po once daily starting on day 8		QTY: <u>37 capsules</u> Refills: <u>0</u>			
<input type="checkbox"/> Zeposia® 7 Day Kit 0.23mg po once daily on days 1-4, then 0.46mg po once daily on days 5-7		QTY: <u>7 capsules</u> Refills: <u>0</u>			
<input type="checkbox"/> Zeposia® .92 mg capsules 1 capsule (0.92mg) po once daily		QTY: <u>30 day supply</u> Refills: _____			
<input type="checkbox"/> Other: _____		QTY: _____ Refills: _____			

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

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. 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.

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