aleracare
advanced specialty pharmacy

Multiple Sclerosis
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Considerations

Diagnosis (ICD 10): ◯ G35 Multiple Sclerosis ◯ Other (please specify):_____

Prior Therapies

Expected date of injection _____/_____/_____

Date of pregnancy test _____/_____/_____

Last injection date _____/_____/_____

Results ◯ + ◯ –

	LEVF	Platelets	ANC	Bilirubin
Result:				
Date:				

Medication	Strength/Directions for Use		Refills
◯ **AVONEX®** (interferon beta 1-a)	◯ 30mcg pre-filled syringe	◯ Inject 30mcg SC once weekly ◯ _____	
◯ **COPAXONE®** (glatiramer acetate)	◯ 20mg pre-filled syringeStart: 400mg SC x 1 on weeks 0, 2, 4 ◯ 40mg pre-filled syringe	◯ Inject 20mg SC once daily ◯ Inject 40mg SC TIW ◯ _____	
◯ **GILENYA®** (fingolimod)	◯ 0.5mg capsule	◯ 1 capsule by mouth daily ◯ _____	
◯ **REBIF®** (interferon beta-1a)	◯ 22mcg prefilled syringe ◯ 44mcg prefilled syringe	◯ Inject 22mcg SC three times weekly ◯ Inject 44mcg SC three times weekly ◯ _____	

◯ 4 week supply REFILL _____ times

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**