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:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (ID & Group #) ◯ Current Medications ◯ History/Progress Notes

Documentation (Required)

◯ CBC with diff ◯ CMP ◯ TSH ◯ Hepatitis B antigen and antibody ◯ quantitative serum Ig

Diagnosis

ICD-10 Codes: ◯ G35 Multiple Sclerosis ◯ Other:_____

Medication	Dose	Directions for Use	Qty	Refills
◯ **AVONEX®** (interferon beta 1-a) ◯ **PFS** ◯ **Sureclick**	◯ 30 mcg/0.5 mL	◯ Inject 30 mcg intramuscularly every week ◯ Other: _____		
◯ **COPAXONE® PFS** (glatiramer acetate) ◯ **GLATOPA®** (glatiramer acetate)	◯ 20 mg/mL ◯ 40 mg/mL	◯ Inject 20 mg subq every day ◯ Inject 40 mg subq three times per week (at least 48 hours apart)		
◯ **GILENYA®** (fingolimod)	◯ 0.5mg capsule	◯ Take one capsule by mouth every day		
◯ **KESIMPTA® Pen** (ofatumumab)	◯ 20 mg/0.4 mL	◯ **Initial:** Inject 20 mg subq at weeks 0, 1, and 2 ◯ **Maintenance:** Inject 20 mg subq every month starting at week 4		
◯ **REBIF® PFS titration pack** (interferon beta-1a) ◯ **REBIF® Pen titration pack** (interferon beta-1a) ◯ **REBIF® PFS** ◯ **REBIF REBIDOSE®**	Titration pack for ◯ 22 mcg/0.5 mL ◯ 44 mcg/0.5 mL ◯ 22 mcg/0.5 mL ◯ 44 mcg/0.5 mL	**Initial:** ◯ (For 22 mcg dose) Inject 4.4 mcg subq three times per week x 2 weeks, then inject 11 mcg subq three times per week x 2 weeks ◯ (for 44 mcg dose) Inject 8.8 mcg subq three times per week x 2 weeks, then inject 22 mcg subq three times per week x 2 weeks **Maintenance (target):** ◯ Inject 22 mcg subq three times per week (at least 48 hours apart) ◯ Inject 44 mcg subq three times per week (at least 48 hours apart)		
◯ **OCREVUS®** (ocrelizumab)	◯ 300 mg/10 mL vial	◯ **Initial:** Infuse 300 mg IV on day 1 and 15 ◯ **Maintenance:** Infuse 600 mg IV every 6 months		
◯ **TECFIDERA®** (dimethyl fumarate)	◯ 120 mg capsule ◯ 240 mg capsule	◯ **Initial:** Take 120 mg by mouth two times per day x 7 days ◯ **Maintenance:** Take 240 mg by mouth two times per day		

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** _____