Multiple Sclerosis Referral Form

Phone: 808-533-8887
Fax: 808-533-1888
E-Prescribing Available

Attention: ______________________ Need By Date: ______________ First Ship To: ☐ Patient ☐ Physician

Patient

Patient Name: ______________________ DOB: ____________ Sex: ☐ Male ☐ Female
Address: ______________________ City: ______________ State: ____________ Zip: __________
Home#: ____________ Work #: ____________ Cell#: ____________ Best time to call: ☐ AM ☐ PM
Soc. Sec #: ______________________ Ethnicity: ____________ Primary Language: ____________
Comorbidities: ______________ Height: ________ Weight: ________ Date: ________
Allergies: ______________________________________ ☐ NKDA

Provider

Physician Name: ______________ Practice Name: ____________ State Lic#: ________ DEA#: ________
Address: ______________ City: ____________ State: ________ Zip: ________ NPI#: ________
Phone#: ____________ Fax#: ____________ Nurse/Key Office Contact: ____________ Ext.: ________

Insurance

Primary Insurance: ______________ ID: ______________ Phone: ______________
Secondary Insurance: ______________ ID: ______________ Phone: ______________
* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info

Diagnosis: ICD-10-CM G35 ☐ Other: ____________
This Rx is: ☐ New therapy ☐ Continuing previous treatment on this agent
Previous drug therapies tried with dates and results: ______________________
____
____
____

Medical Assessment
Type of MS:
☐ Primary Progressive
☐ Secondary Progressive
☐ Relapsing – Remitting
☐ Other: ____________

For maintenance therapy, has pt had a poor response to therapy as indicated by at least one of the following: Increase of ≥ 1 point on the EDSS, multiple relapses in a short time span (≥ relapses in 6 months after 1 yr of therapy), development of new neurologic deficits, or deterioration evident on MRI?
☐ Yes ☐ No

Prescription

Medication	Strength	Directions	Quantity	Refill
☐ **Betaseron®**	☐ 0.0625 mg ☐ 0.25 mg	☐ SQ every other day; increase over 6 wks to 0.25 mg SQ every other day (induction) ☐ SQ every other day (maintenance)	28 days supply	
☐ **Copaxone®**	20 mg	☐ SQ every day ☐ Alternate Dosing: ____________	30 days supply	
☐ **Rebif® Starter Pack**	<u>22 mcg Titration Schedule</u> ☐ Week 1-2: 4.4 mcg (0.1 ml) SQ TIW ☐ Week 3-4: 11 mcg (0.25 ml) SQTIW ☐ Week 5+: 22 mcg (0.5 ml) SQTIW	<u>44 mcg Titration Schedule</u> ☐ Week 1-2: 8.8 mcg (0.1 ml) SQ TIW ☐ Week 3-4: 22 mcg (0.25 ml) SQ TIW ☐ Week 5+: 44 mcg (0.5 ml) SQ TIW		
☐ **Rebif®**	☐ 22 mcg Maintenance ☐ 44 mcg Maintenance	☐ TIW (48 hours apart) ☐ Alternate Dosing: ____________	28 days supply	
☐ **Gilenya®**	0.5 mg	☐ Oral 0.5 mg Daily ☐ Alternate Dosing: ____________	28 days supply	
☐ **Tysabri®**	300 mg/15ml	300 mg IV infusion over 1 hour every 4 weeks		
Other: ________				

Physicians Signature: ______________________ Date: ____________

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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