MS
Prescription Referral Form

Phone: 1-877-592-7988
Fax: 1-800-787-0874

Rosemont Specialty Pharmacy
www.rosemontspecialtyrx.com

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Specialty Pharmacy
Expires 01/01/2020

Date Medication Needed: _____ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** ○ Male ○ Female **Height:** _____ **Weight:** _____ ○ lbs. ○ kg.
Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____
Address: _____ **Phone:** _____ **Fax:** _____
City, State, Zip: _____ **Key Contact:** _____ **Phone:** _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: CM G35 Multiple Sclerosis ☐ **Other:** _____
Has the patient been previously treated for this condition? ○ Yes ○ No
Prior failed medication (medication and duration of treatment/reason for d/c):
☐ _____
Patient currently on therapy? ○ Yes ○ No Medication(s): _____
Will patient be stoping above medication before starting new therapy?
○ Yes ○ No Discontinuation Date: _____
Is prescriber a Neurologist? If no, please include neurology consult if available.
Diagnosis: ☐ **Other:** _____

Number of relapses in past year: _____
Last MRI date: _____ **Any MRI changes?** ○ Yes ○ No
Inection training completed by:
Novantrone:
Is patient's LVEF <50%? ○ Yes ○ No
What is lifetime (cumulative) Novantrone dose (mg/m2)? _____
Copy of last CBC with differential: _____
Is patient pregnant, nursing or planning pregnancy? ○ Yes ○ No ○ N/A
☐ **Serum Creatine** _____ ☐ **Creatinine Clearance** _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Avonex®**	☐ AVOSTARTGRIP Titration Kit ☐ 30mcg Prefilled Syringe #4 ☐ 30mcg Pen #4	☐ **Dose Titration:** • Week 1: Inject 7.5mcg IM once weekly • Week 2: Inject 15mcg IM once weekly • Week 3: Inject 22.5mcg IM once weekly • Week 4+: Inject 30mcg IM once weekly ☐ Inject 30mcg IM once weekly	4 week supply	0
☐ **Betaseron®**	☐ 0.3mg vial	☐ **Dose Titration:** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ **Maintenance Dose:** 0.25mg /1ml subcutaneously QOD ☐ **Other:**	4 week supply	0
☐ **Copaxone®**	☐ 20mg Prefiled Syringe ☐ 40mg Prefiled Syringe	☐ 20mg SQ QD ☐ 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week	4 week supply	
☐ **Extavia®**	☐ 0.3mg vial	☐ **Dose Titration:** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ **Maintenance Dose:** 0.25mg /1ml subcutaneously QOD ☐ **Other:**	4 week supply	0
☐ **Glatopa®**	☐ 20mg Prefiled Syringe	☐ 20mg SQ QD	4 week supply	
☐ **Gilenya®**	☐ 0.5mg capsule	☐ Take 0.5mg po QD	4 week supply	
☐ **Rebif®** ☐ **Rebif Redidose®**	☐ Titration Pack (8.8mcg/22mcg) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe	☐ Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) ☐ **Maintenance:** Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Maintenance:** Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Other:**	4 week supply	0

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

I authorize Rosemont Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient do not distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.

# of Prescriptions: _____