Multiple Sclerosis
Prescription Referral Form
ESCRIBE #: 5100174
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

urac ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Dose/Strength	Sig/Directions	Qty	Refills
☐ **Avonex®**	☐ AVOSTARTGRIP Titration Kit ☐ 30mcg Preilled 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	
☐ **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	
☐ **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	
☐ **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)	4 week supply	

Ship to: ☐ Patient ☐ Office ☐ Other

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

Patient Signature:	Date:

5. Physician Information:

INJECTION TRAINING: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.