Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Avella Specialty Pharmacy | MS Prescription Referral Form

Send your Rx to: | Choose Location

avella.com
If you have questions or concerns, please contact us

Date Medication Needed: _____ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up (store location): _____ Injection training by pharmacy? ☐

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: 1151 Old York Road, Suite 200 **Phone:** 215-957-9250 **Fax:** 215-957-9254

City, State, Zip: Abington, PA 19001 **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

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____