BioPlus® Specialty Pharmacy
A CAREPATHrx Company
www.bioplusrx.com

NEUROLOGY & MULTIPLE SCLEROSIS REFERRAL FORM

Surescripts ID #: CPR10785350213549930
Office: 1-888-292-0744
Fax Referral #: 1-800-269-5493

Referral Info

PATIENT INFORMATION

Patient Name:		SSN:		DOB:
Address:		City:	State:	Zip:
Home Address:	Cell Phone:	Height:	Weight:	Gender: ☐ Male ☐ Female
Email Address:		Diagnosis Code:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Phone:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

PRIOR TREATMENT HISTORY

☐ AVONEX® ☐ BETASERON® ☐ COPAXONE® ☐ GILENYA® ☐ Rebif® ☐ Other_____

MS MEDICATIONS

AMPYRA® (dalfampradine)*
☐ 10 mg by mouth every 12 hours
Qty: 60 Refills: ☐

AVONEX® (interferon beta-1a)* ☐ Enroll in Above MS™
30 mcg (☐ Prefilled Syringe ☐ Pen) Inject IM once weekly
Qty: 4 Refills: ☐

BETASERON® (interferon beta-1b)* ☐ Enroll in BETAPLUS®
☐ **Starting Titration:** 62.5 mcg SubQ every other day for weeks 1 and 2, 125 mcg SubQ every other day for weeks 3 and 4, 187.5 mcg SubQ every other day for weeks 5 and 6, 250 mcg SubQ every other week for weeks 7 and 8
Qty: 30 days Refills: 1
☐ **Maintenance Dosing:** 250 mcg (1 ml) SubQq every other day
☐ BetaConnect
Qty: 14 Refills: ☐

COPAXONE® (glatiramer acetate) * ☐ Enroll in Shared Solutions® ☐ Enroll in Mylan ADVOCATE®
☐ 20 mg SubQ every day ☐ 40 mg SubQ three times per week
Qty: 28 days Refills: ☐

TECFIDERA® (dimethyl fumarate) *
☐ 120 mg (14 per bottle 7 day supply) ☐ 240 mg (60 per bottle 30 day supply)
☐ **Starting Dose:** 120 mg twice a day, by mouth, day 1 through 7
☐ **Maintenance Dosing:** Starting day 8, 240 mg by mouth twice daily
Qty: ☐ Refills: ☐

KESIMPTA®(ofatumumab)
☐ Sensoready® Pen ☐ Prefilled Syringe
☐ **Starting Dose:** 20 mg administered at week 0, 1, and 2
☐ **Maintenance Dosing:** 20 mg administered monthly starting at week 4
Qty: ☐ Refills: ☐

EXTAVIA®(interferon beta-1b)☐ Extavia Go Program®
☐ **Starting Titration:** 62.5 mcg SubQ every other day for weeks 1 and 2, 125 mcg SubQ every other day for weeks 3 and 4, 187.5 mcg SubQ every other day for weeks 5 and 6, 250 mcg SubQ every other week for weeks 7 and 8
Qty: 30 days Refills: 1
☐ **Maintenance Dosing:** 250 mcg (1 ml) SubQ every other day
Qty: 15 Refills: ☐

GILENYA® (fingolimod) ☐ Enroll in Gilenya Go Program®
☐0.5 mg by mouth once a day
Qty: 30 Refills: ☐

Glatopa™ (glatiramer acetate injection) ☐ Enroll in GlatopaCare™
☐ 20 mg SubQ every day ☐ 40 mg SubQ three times per week
Qty: 28 days Refills: ☐

MAYZENT® (siponimod)
☐ Please complete Mayzent Prescription Start Form and attach to this referral form.

OCREVUS™ (ocrelizumab)
☐ **Starting Dose:** 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion
☐ **Maintenance:** 600 mg intravenous infusion every 6 months
Qty: ☐ Refills: ☐

OZOBAX™ (baclofen) 5 mg/ml Oral Solution
☐ Goal Dose: ___ mg/day (should be divided into 3-4 doses)
Directions: Increase dose slowly every 3 days by 5 mg PO 3 times/day up to goal dose

PLEGRIDY® (peginterferon beta-1a)
Induction: ☐ Prefilled Syringe ☐ Pen
63 mcg SubQ on Day 1, 94 mcg SubQ on day 15
Qty: 1 pack Refills: None
Maintenance: 125 mcg/0.5 ml ☐ Prefilled Syringe ☐ Pen
125 mcg SubQ every 14 days, starting day 29 of therapy
Qty: 2 Refills: ☐

Rebif® (interferon beta-1a) ☐ Enroll in MS LifeLines®
☐ Prefilled Syringe/Rebiject II®* ☐Rebif Rebidose®
Titration Pack:
☐ Goal Dose 22 mcg: (Full dose therapy beginning week 5) 4.4 mcg/0.1 ml SubQ three times weekly week 1-2, 11 mcg/0.25 mLSubQ three times weekly weeks 3-4
☐ Goal Dose 44 mcg: (Full dose therapy beginning week 5) 8.8 mcg/0.1 ml SubQ three times weekly week 1-2, 22 mcg/0.25 ml three times weekly weeks 3-4
Qty:: 1 pack Refills: None
Maintenance Dosing:
☐ 44 mcg ☐ 22 mcg SubQ three times per week
Qty:: 12 Refills: ☐
***Rebiject** (Will come from MS Lifelines®)

VUMERITY™ (diroximel fumarate)
☐ **Starting Dose:** 231 mg twice a day, orally, for 7 days
☐ **Maintenance:** 462 mg (administered as two 231 mg capsules) twice a day, orally
Qty: ☐ Refills: ☐

ZEPOSIA® (ozanimod)
☐ **7- day titration:** Days 1 to 4: Give 0.23 mg by mouth once daily. Days 5 to 7: Give 0.46 mg by mouth once daily
Qty: 1 Refills: None
☐ **Maintenance Dosing:** Starting Day 8, 0.92 mg by mouth once daily
Qty: 30 Refills: ☐ ***AVAILABLE IN GENERIC**

☐ OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone: 215-957-9250	Fax: 215-957-9254
Office Contact	Email:	Ship To: ☐ Patient ☐ MD Office
NPI #:	Tax ID #	
Prescriber Signature:		Date

Your signature authorizes BioPlus Specialty Pharmacy Services, Inc., and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, and Route 300 Pharmacy (the "BioPlus Pharmacies"), to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

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