MULTIPLE SCLEROSIS REFERRAL FORM

NPI #: 1801060298
BIOMATRIX **TEL:** 855-359-9679 **FAX:** 610-545-6030

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT
Abington Neurological Associates	1151 Old York Rd, Ste 200, Abington, PA 19001	215-957-9250	

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Code ☐ **G35** Multiple Sclerosis OR ☐ Other_____ Patient Weight _____
☐ Relapse Remitting ☐ Primary Progressive ☐ Secondary Progressive
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work _____
Comments_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AMPRYRA** (dalfampridine) **10 mg extended release tablet**
SIG: ____ mg PO twice daily QTY:_____ Refills: _____

☐ **AUBAGIO** (teriflunomide)
☐ SIG: 7 mg: 1 tablet by mouth daily with or without food
☐ SIG: 14 mg: 1 tablet by mouth daily with or without food
QTY: _____ Refills: _____

☐ **AVONEX** (interferon beta-1a) **30mcg**
Dispense: ☐ Pen ☐ PFS
☐ SIG: Inject 30 mcg IM once weekly
☐ SIG: Other _____
QTY: 1 pack = 4 week supply Refills: _____

☐ **BETASERON** (interferon beta-1b) **0.3 mg vial**
☐ **EXTAVIA VIALS** (interferon beta-1b) **0.3 mg vial**
Starting Dose
☐ Inject 0.0625 mg (0.25 mL) subcutaneously every other day for weeks 1 & 2 QTY: 1 pack Refills: 0
☐ Inject 0.125 (0.5 mL) subcutaneously every other day for weeks 3 & 4 QTY: 1 pack Refills: 0
☐ Inject 0.1875 (0.75 mL) subcutaneously every other day for weeks 5 & 6 QTY: 1 pack Refills: 0
Maintenance Dose:
☐ Inject 0.25 mg (1 mL) subcutaneously every other day
☐ Other _____
QTY: 1 pack = 4 week supply Refills: _____

☐ **COPAXONE** (glatiramer acetate)
☐ **GLATOPA** (glatiramer acetate) ☐ **GLATIRAMER ACETATE**
Dose: ☐ 20 mg PFS ☐ 40 mg PFS
☐ SIG: Inject 20 mg subcutaneously once daily QTY: 30 Refills: _____
☐ SIG: Inject 40 mg subcutaneously three times a week QTY: 12 Refills: _____
☐ SIG: Other _____
QTY: _____ Refills: _____

☐ **GILENYA** (fingolimod) **0.5 mg** *(first dose must be taken at the doctor's office)*
SIG: >40kg: 1 capsule by mouth daily QTY: _____ Refills: _____

☐ **LEMTRADA** (alemtuzumab) **12 mg/1.2 mL(10 mg/mL) vial**
☐ **First course:** 12 mg/day on 5 consecutive days QTY: 5 vials
☐ **Second course:** 12 mg/day on 3 consecutive days 12 months after first treatment course. QTY: 3 vials
☐ **Maintenance course:** 12 mg/day on 3 consecutive days 12 months after the last dose of the prior treatment course. QTY: 3 vials
☐ Other _____ QTY: _____

☐ **OCREVUS** (ocrelizumab) **300 mg/10 mL vial**
☐ **Loading Dose**: Infuse 300 mg IV on Day 1 followed by 300 mg IV 2 weeks later QTY: 2 Vials Refills: 0
☐ **Maintenance Dose** *(beginning 6 months after first 300 mg dose)*
Infuse 600 mg IV once every 6 months QTY: 2 vials Refills: _____

REBIF (interferon beta-1a)
☐ **REBIF 22mcg Prescribed Dose**
☐ **REBIF TITRATION PACK**
SIG: Inject 4.4 mcg (0.1 mL) subcutaneously TIW (at least 48hrs apart) weeks 1 & 2. Then inject 11 mcg (0.25 mL) TIW weeks 3 & 4
QTY: 1 pack Refills: 0
☐ **REBIF** (interferon beta-1a) **22 mcg/0.5ml**
Dispense: ☐ Pen ☐ PFS
SIG: 22 mcg (0.5ml) subcutaneously TIW (at least 48hrs apart)
QTY: 1 pack = 4 week supply Refills: _____
☐ **REBIF 44mcg Prescribed Dose**
☐ **REBIF TITRATION PACK**
SIG: Inject 8.8 mcg subcutaneously TIW (at least 48hrs apart) weeks 1 & 2. Then inject 22 mcg TIW weeks 3 & 4 QTY: 1 pack Refills: 0
☐ **REBIF** (interferon beta-1a) **44mcg/0.5ml**
Dispense: ☐ Pen ☐ PFS
SIG: 44 mcg (0.5ml) subcutaneously TIW (at least 48hrs apart) starting week 5 and thereafter
QTY: 1 pack = 4 week supply Refills: _____

☐ **TYSABRI** (natalizumab) **300 mg vial**
SIG: Infuse 300mg IV over 1 hour every 4 weeks QTY: 1 vial Refills: _____

☐ **OTHER** _____
SIG: _____ QTY: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____
Prescriber's Email_____

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