RICHMOND PHARMACY Specialty Script

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Date: ____/____/____ Needs by Date: ____________

Language: ________________ ☐ Nursing Instruction Required

Ship to: ☐ Patient ☐ MD Office

NEUROLOGY MS REFERRAL FORM

Prescriber's Name: ______________________ DEA #: ____________ NPI: ____________

Address: ______________________ City, State, Zip: ______________________

Phone: ______________ Fax: ______________ Office Contact: ______________

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: ______________________ Date of Birth: ____/____/____ Gender: ☐F ☐M

Address: ______________________ City, State, Zip: ______________________

Home Phone: ______________ Alternate: ______________ Email: ______________

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

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 stopping above medication before starting new therapy?

☐ Yes ☐No Discontinuation Date: ____________

Is prescribe 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** ____________

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
☐ **AVONEX (interferon beta-1a)**	☐ 30mcg prefilled syringe - Inject intramuscularly once a week ☐ 30mcg single dose vial - Inject intramuscularly once a week	☐ 4-Week supply (1 kit) ☐ 12-Week supply (3 kits)	
☐ **BETASERON (interferon beta-1b)**	☐ 0.3mg - Inject 0.25mg (1ml) subcutaneously every other day ☐ **Dose Titration** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD (every other day) • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD (every other day) • Weeks 5-6: Inject 0.1875mg/0.75ml subcutaneously QOD (every other day) • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD (every other day)	☐ 28-Day supply (1 kit of 14 vials) ☐ 84-Day supply (3 kits of 14 vials) ☐ Other:	
☐ **COPAXONE (glatiramer acetate injection)**	☐ 20mg prefilled syringe - Inject subcutaneously daily	☐ 30-Day supply (1 kit) ☐ 90-Day supply (3 kits)	
☐ **EXTAVIA (interferon beta-1b)**	☐ 0.3mg - Inject 0.25mg (1ml) subcutaneously every other day ☐ **Dose Titration** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD (every other day) • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD (every other day) • Weeks 5-6: Inject 0.1875mg/0.75ml subcutaneously QOD (every other day) • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD (every other day)	☐ 30-Day supply (1 kit) ☐ 90-Day supply (3 kits)	
☐ **GILENYA (fingolimod capsules)**	☐ 0.5mg - Take one capsule by mouth daily	☐ 28-Day supply (1 kit) ☐ 84-Day supply (3 kits) ☐ Other:	
☐ **OCREVUS** ☐ Initial Dose (two infusions) ☐ Subsequent Doses (one infusion)	☐Iinfusion 1: 300 mg in 250 ml ☐Infusion 2 (2 weeks later): 300 mg in 250 ml • Start at 30 ml per hour • Increase by 30 ml per hour every 30 minutes • Maximum: 180 ml per hour • Duration: 2.5 hours or longer ☐One infusion every 6 months: 600 mg in 500 ml • Start at 40 ml per hour • Increase by 40 ml per hour every 30 minutes • Maximum: 200 ml per hour • Duration: 3.5 hours or longer		
☐ **REBIF (interferon beta-1a)** ☐ 22mcg prefilled syringe ☐ 44mcg prefilled syringe ☐ Titration pack (six 8.8mcg & six 22mcg prefilled syringes)	☐ Weeks 1-2: Inject 8.8mcg subcutaneously 3 times a week Weeks 3-4: Inject 22mcg subcutaneously 3 times a week Week 5: Inject 44mcg subcutaneously 3 times a week ☐ Inject 44mcg subcutaneously 3 times a week ☐ Other:	☐ 4-Week supply (1 kit) ☐ 12-Week supply (3 kits) ☐ Other:	
☐ **TYSABRI (natalizumab)**	☐ 20mg prefilled syringe Directions:	☐ Enter quantity/duration:	

NEWLY APPROVED THERAPIES

Physician Signature: ______________________ Date: ______________________

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

For additional information please visit our website **www.RichmondSpecialty.com**

ePrescribe to our pharmacy "Richmond Pharmacy Specialty" • **(718) 818-2178**