Faxed or E-scribed Prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

Access Specialty Pharmacy

Multiple Sclerosis (MS) Prescription Referral Form

Send your RX to: Access Specialty Pharmacy
Fax: 661-489-3553

If you have any questions or concerns,
Please contact us at 661-489-3500 or toll free (833-647-0821)

Date Medication Needed: _____ **Deliver to**: ☐ Patient's home ☐ Prescriber's office ☐ Pick-up

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#:**_____
Address: _____ **Phone:** _____ **Fax:** _____
City, State, ZIP: _____ **Key Contact:** _____ **Phone:**_____

3: Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, Tests, with the prescription

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 discontinuation):
_____
Patient currently on therapy? ☐ **Yes** ☐ **No Medication(s):**_____
Will patient be stopping 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**
Injection Training completed? ☐ **Yes** ☐ **No**
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 Creatinine:_____ **Creatinine Clearance:**_____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Avonex**	AVOSTARTGRIP Titration Kit ☐ 30 mcg/0.5 ml Prefilled Syringe # 4 ☐ 30 mcg/0.5 ml Pen # 4	Dose Titration: -Week 1: Inject 7.5 mcg IM once weekly -Week 2: Inject 15 mcg IM once weekly -Week 2: Inject 22.5 mcg IM once weekly -Week 4: Inject 30 mcg IM once weekly	4 week supply	
☐ **Betaseron**	☐ 0.3 mg vial SQ	Dose Titration: -Weeks 1-2: Inject 0.0625mg/0.25ml SQ every other day -Weeks 3-4: Inject 0.125mg/0.50ml SQ every other day -Weeks 5-6: Inject 0.1875mg/0.75ml SQ every other day -Weeks 7+: Inject 0.25mg/1ml SQ every other day Maintenance Dose: Inject 0.25mg/1ml SQ every other day Other:_____	4 week supply	
☐ **Copaxone**	☐ 20mg/ml Prefilled Syringe ☐ 40 mg/ml Prefilled Syringe	☐ 20mg SQ once daily ☐ 40mg SQ 3 times per week, at least 48 hours apart on the same 3 days each week	4 week supply	
☐ **Extavia**	☐ 0.3 mg vial preservative free SQ	Dose Titration: -Weeks 1-2: Inject 0.0625mg/0.25ml SQ every other day -Weeks 3-4: Inject 0.125mg/0.50ml SQ every other day -Weeks 5-6: Inject 0.1875mg/0.75ml SQ every other day -Weeks 7+: Inject 0.25mg/1ml SQ every other day Maintenance Dose: Inject 0.25mg/1ml SQ every other day Other:_____	4 week supply	
☐ **Glatopa**	☐ 20 mg/ml Prefilled Syringe ☐ 40 mg/ml prefilled syringe	☐ 20 mg SQ once daily	4 week supply	
☐ **Gilenya**	☐ 0.25 mg capsule ☐ 0.5mg capsule	☐ Take 0.5 mg by mouth once daily	4 week supply	
☐ **Rebif** ☐ **Rebif Rebidose autoinjector**	☐Titration Pack (8.8mcg/22mcg) prefilled syringe or autoinjector ☐ 22mcg/0.5 ml Prefilled Syringe or autoinjector ☐ 44 mcg Prefilled Syringe or autoinjector	☐ Inject 8.8 mcg SQ 3 times per week on weeks 1-2 ☐ 22 mcg SQ 3 times per week on weeks 3-4, and 44 mcg SQ 3 times per week on weeks 5+ (48 hours apart) Maintenance Dose: Inject 22 mcg (0.5ml) SQ 3 times per week (48 hours apart) Maintenance Dose: Inject 44 mcg (0.5ml) SQ 3 times per week (48 hours apart) Other:_____	4 week supply	

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 Permissible** **Date**

# of Prescriptions: _____

I authorize Access Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process