

MULTIPLE SCLEROSIS REFERRAL FORM

54 Conchester Road Glen Mills, PA 19342
 1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

NEW PATIENT CURRENT PATIENT

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 ICD-9 Diagnosis Code 340 Multiple Sclerosis **OR** Other _____ Weight _____ Allergies _____
 Patient currently on therapy Yes No Date of next blood work _____ Comments _____

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# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AVONEX ADMINISTRATION PACK 30mcg PreFilled

SIG Inject 30mcg IM once weekly
 Other _____
 QTY # _____ Weeks (1 pack = 4 week supply) Refills x _____

BETASERON 0.3mg Vials

SIG Inject _____ SC every other day
 Other _____
 QTY # _____ Weeks (1 box = 4 week supply) Refills x _____

COPAXONE 20mg/2ml Syringe

SIG Inject 20mg (2ml) SC once daily
 Other _____
 QTY # _____ Syringes Refills x _____

REBIF TITRATION PACK 12 syringes

SIG 8.8mcg SQ TIW - weeks 1 & 2 22mcg SQ TIW - weeks 3 & 4
 Maintenance Dose following week 3 & 4

REBIF 22mcg/0.5ml

SIG 22mg (0.5ml) SQ TIW (48hrs apart)

REBIF 44mcg/0.5ml (maintenance)

SIG starting week 5: 44mcg (0.5ml) SQ TIW (48hrs apart)
 QTY # _____ Boxes (1 box = 4 week supply) Refills x _____

OTHER

SIG _____ QTY _____ Refills x _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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