Across Specialty Pharmacy

MULTIPLE SCLEROSIS REFERRAL FORM (A-K)

PH (770) 746 0130 | FAX (770) 746 0131
NCPDP 1175288 | NPI 1275142614

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

CLINICAL INFORMATION

ICD-10 Code ☐ G35 Multiple Sclerosis ☐ Other:	Date of Diagnosis or Years with Condition			
Type of MS ☐ Relapsing ☐ Progressive Relapsing ☐ Primary Progressive ☐ Secondary Progressive ☐ Clinically Isolate Syndrome	Date of Last Relapse (if applicable):			
☐ New to Therapy ☐ Therapy Restart ☐ Existing Treatment	Expected Therapy Start Date/Date Med Needed			
Allergies ☐ NKDA ☐ Yes (please list)	☐ Other Allergies (please list)			
Past Meds Tried/Failed (please list)				
Other/Concomitant Medications (please list)				
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in): Weight (kg/lbs): Date Obtained:			
Ship to Address ☐ Home ☐ Prescriber's Address ☐ Other (please list)				

PRESCRIPTION INFORMATION

Medication	Dose / Strength	DIRECTIONS	Qty	Refills
☐ Avonex	☐ 30 mcg PFS ☐ 30 mcg Autoinjector	☐ Maintenance Dose: Inject 30 mcg (0.5 mL) IM every 7 days.	28-Day (1 Box)	
☐ Betasero	☐ 0.3 mg KIT (14 Vials)	☐ Dose Titration: • Weeks 1&2: Inject 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: Inject 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: Inject 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: Inject 0.25 mg (1 mL) SubQ every other day	1 Box	1
		☐ Maintenance Dose: Inject 0.25 mg (1 mL) SubQ every other day	28-day	
☐ Copaxone	☐ 20 mg PFS	☐ Inject 20 mg SubQ once daily	30-day	
	☐ 40 mg PFS	☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-day	
☐ Dalfampridine ER	☐ 10 mg Tablet	☐ Take 10 mg by mouth twice daily, approximately 12 hours apart.	30-day	
☐ Extavia‡	☐ 0.3 mg KIT (15 Vials)	☐ Dose Titration: • Weeks 1&2: Inject 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: Inject 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: Inject 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: Inject 0.25 mg (1 mL) SubQ every other day	1 Box	1
		☐ Maintenance Dose: Inject 0.25 mg (1 mL) SubQ every other day	30-day	
☐ Gilenya‡ **indicate First Dose Observation (FDO) status*	☐ 0.5 mg capsule	☐ Take 0.5 mg by mouth once daily. ☐ Continuation of therapy; FDO completed ☐ FDO planned – Date: _____	30-day	
☐ Glatiramer Acetate	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg SubQ once daily	30-Day	
		☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-Day	
☐ Glatopa	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg SubQ once daily	30-Day	
		☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-Day	
☐ Kesimpta *HBV & quantitative serum Ig screening required before 1st dose*	☐ 20 mg Autoinjector	☐ Loading Dose: Inject 20 mg (0.4 mL) SubQ at Weeks 0, 1 and 2.	3 Units	0
		☐ Maintenance Dose: Inject 20 mg (0.4 mL) SubQ monthly starting at week 4.	1 Unit	

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

Across Specialty Pharmacy

MULTIPLE SCLEROSIS REFERRAL FORM (L-R)

PH (770) 746 0130 | FAX (770) 746 0131
NCPDP 1175288 | NPI 1275142614

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice / Facility Name	Prescriber Name / Specialty		
Address	City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #

CLINICAL INFORMATION

ICD-10 Code ☐ G35 Multiple Sclerosis ☐ Other:	Date of Diagnosis or Years with Condition
Type of MS ☐ Relapsing ☐ Progressive Relapsing ☐ Primary Progressive ☐ Secondary Progressive ☐ Clinically Isolate Syndrome	Date of Last Relapse (if applicable):
☐ New to Therapy ☐ Therapy Restart ☐ Existing Treatment	Expected Therapy Start Date/Date Med Needed
Allergies ☐ NKDA ☐ Yes (please list)	☐ Other Allergies (please list)
Past Meds Tried/Failed (please list)	
Other/Concomitant Medications (please list)	
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in): Weight (kg/lbs): Date Obtained:
Ship to Address ☐ Home ☐ Prescriber's Address ☐ Other (please list)	

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Dose Direction	Qty	Refills
☐ Mayzent *1 mg daily dosing*	☐ 0.25 mg tablets	☐ Dose Titration to 1 mg: • Day 1&2: Take 0.25 mg PO once daily • Day 3: Take 0.50 mg PO once daily • Day 4: Take 0.75 mg PO once daily • Day 5+: Take 1 mg PO once daily	12 Tablets	0
		☐ Maintenance Dose: Take 1 mg PO once daily	28-Day	
☐ Mayzent *2 mg daily dosing*	☐ 2 mg tablets	☐ Dose Titration to 2 mg: Reference www.mayzenthcp.com for the "Start Form: or call 877.629.9368 for the starter pack		
		☐ Maintenance Dose: Take 2 mg PO once daily.	30-Day	
☐ Ocrevus	☐ 300 mg/10 mL SDV	☐ Initial Dose: Infuse 300 mg IV on Day 1, followed by a second 300 mg IV infusiontwo weeks later	2 Vials (6 Months)	0
		☐ Maintenance Dose: Infuse 600 mg IV once every six months (begin 6 months after thefirst 300 mg dose)	2 Vials (6 Months)	
☐ Plegridy *Starter Pack*	☐ PFS ☐ Autoinjector	☐ IM Initial Dose: Inject 63mcg IM on day 1 then inject 94mcg IM on day 15 ☐ SubQ Initial Dose: Inject 63mcg SubQ on day 1 then inject 94mcg SubQ on day 15	28-day	
☐ Plegridy *Maintenance Dose*	☐ 125 mcg (PFS) ☐ 125 mcg (Autoinjector)	☐ IM Maintenance Dose: Inject 125mcg (0.5ml) IM every 14 days ☐ SubQ Maintenance Dose: Inject 125mcg (0.5ml) SubQ every 14 days	28-Day	
☐ Rebif *Titration Pack* *Initial Dosing*	☐ PFS ☐ Rebidose Autoinjector Titration Packs Contain: 6x8.8 mcg devices 6x22mcg devices	☐ Loading Dose (22 mcg target dose) (PFS Only): • Weeks 1&2: Inject 4.4 mcg SubQ three times weekly • Weeks 3&4: Inject 11 mcg SubQ three times weekly • Weeks 5+: Inject 22 mcg SubQ three times weekly ☐ Separate doses by at least 48 hours.	1 Pack (28-Day)	0
		☐ Loading Dose (44 mcg target dose): • Weeks 1&2: Inject 8.8 mcg SubQ three times weekly • Weeks 3&4: Inject 22 mcg SubQ three times weekly • Weeks 5+: Inject 44 mcg SubQ three times weekly ☐ Separate doses by at least 48 hours.	1 Pack (28-Day)	0
☐ Rebif *Maintenance Dosing*	☐ 22 mcg Autoinjector ☐ 22 mcg PFS	☐ Maintenance Dose: Inject 22 mcg (0.5 mL) SubQ three times weekly. Separate doses by at least 48 hours.	28-day	
	☐ 44 mcg Autoinjector ☐ 44 mcg PFS	☐ Maintenance Dose: Inject 44 mcg (0.5 mL) SubQ three times weekly. Separate doses by at least 48 hours.	28-day	

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

Across Specialty Pharmacy

MULTIPLE SCLEROSIS REFERRAL FORM (S-Z)

PH (770) 746 0130 | **FAX** (770) 746 0131
NCPDP 1175288 | **NPI** 1275142614

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice / Facility Name	Prescriber Name / Specialty		
Address	City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #

CLINICAL INFORMATION

ICD-10 Code ☐ G35 Multiple Sclerosis ☐ Other:		Date of Diagnosis or Years with Condition	
Type of MS ☐ Relapsing ☐ Progressive Relapsing ☐ Primary Progressive ☐ Secondary Progressive ☐ Clinically Isolate Syndrome		Date of Last Relapse (if applicable):	
☐ New to Therapy ☐ Therapy Restart ☐ Existing Treatment		Expected Therapy Start Date/Date Med Needed	
Allergies ☐ NKDA ☐ Yes (please list)		☐ Other Allergies (please list)	
Past Meds Tried/Failed (please list)			
Other/Concomitant Medications (please list)			
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:		Patient Height (cm/in): Weight (kg/lbs): Date Obtained:	
Ship to Address ☐ Home ☐ Prescriber's Address ☐ Other (please list)			

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Dose Directions	Qty	Refills
☐ Tecfidera	☐ Titration / Starter Pack 14 x 120 mg capsules 46 x 240 mg capsules	☐ Initial Dose: Take 120 mg by mouth twice daily for seven days. Then, take 240 mg by mouth twice daily.	30-day	
	☐ 240 mg capsule ☐ 120 mg capsule	☐ Maintenance Dose: Take 240 mg by mouth twice daily.	30-day	
		☐ Maintenance Dose: Take 120 mg by mouth twice daily.	28-Day	
☐ Vumerity	☐ 231 mg capsule	☐ Initial Dose: Take 231 mg by mouth twice daily for seven days. Then, take 462 mg (2x231 mg) by mouth twice daily.	106 Capsules	0
		☐ Maintenance Dose: Take 462 mg (2x231 mg) by mouth twice daily.	30-day	
☐ Zeposia	☐ Starter Kit Kit contains: 4x0.23 mg caps 3x0.46 mg caps 30x0.92 mg caps	☐ Initial Dose: Days 1-4: Take one 0.23 mg capsule by mouth once daily x 4 days Days 5-7: Take one 0.46 mg capsule by mouth once daily x 3 days Day 8 and thereafter: Take one 0.92 mg capsule by mouth once daily	1 Kit	0
	☐ 0.92 mg Capsule	☐ Maintenance Dose: Take one capsule by mouth once daily	☐ 30-day	

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____