Multiple Sclerosis Referral Form

Please complete and attach to MDX prior Authorization form

MDX Hawai'i

PATIENT INFORMATION:	PHYSICIAN INFORMATION:
Patient Name: ______	Physician Name: ______
Address: ______	State LIC #______ DEA #______ NPI #______
City: ______ State: ______ Zip: ______	Address: ______
Home Phone: ______ Cell Phone: ______	City: ______ State: ______ Zip: ______
Patient Soc. Sec #: ______	Phone: ______ Fax: ______
Date of Birth: ______ Sex: ☐ Male ☐ Female	Nurse/Key Office Contact: ______
Weight: ______ ☐ lbs ☐ kg Height: ______ BMI: ______	

INSURANCE INFORMATION: ☐ Demographic sheet ☐ Universal claim form ☐ Insurance cards

*Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)

DIAGNOSTIC INFORMATION:

☐ Multiple Sclerosis ICD-9CM 340. ☐ Other Diagnosis:

- Has patient been treated previously for this condition? ☐ Yes ☐ No Medication(s) failed: ______
- Is patient currently on therapy? ☐ Yes ☐ No Type /medication(s): ______
- will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No

If yes, How long should patient wait before starting the new medication? ______

- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): ____

PRESCRIPTION:

MEDICATION & DIRECTIONS	ALTERNATE DOSAGE	QTY	REFILL
☐ **Copaxone®** prefilled syringes ☐ **Copaxone Autoject®** ☐ 20 mcg SQ every day ☐ 40 mcg SQ TIW ☐ ***Enroll in Share Sol℠***			
☐ **Avonex®** prefilled syringes ☐ **Avonex®** vial dose ☐ 30 mcg IM weekly ☐ ***Enroll in MS ActiveSource℠***			
☐ **Rebif®** Titration Pack ☐ **Rebiject®** Auto Injection ☐ ***Enroll in MS Lifelines℠***			
☐ Dose Titration: Week 1 & 2: 4.4 mcg or 8.8 mcg SQ TIW (48 hrs apart) then Week 3 & 4: 11 mcg or 22mcg SQ TIW (48 hrs apart)			
Week 5 +: 22mcg or 44mcg SQ TIW (48 hrs apart): (No refills on starting dose unless it is specified by MD)			
☐ **Rebif®** 22 mcg prefilledsyringes ☐ **Rebiject®** Auto Injection 22 mcg SQ TIW (48 hours apart) ☐ ***Enroll in MS Lifelines℠***			
☐ **Rebif®** 44 mcg prefilled syringes ☐ **Rebiject®** Auto Injection 4.4 mcg SQ TIW (48hours apart) ☐ ***Enroll in MS Lifelines℠***			
☐ **Betaseron®** ☐ ***Enroll in Beta Plus MS®***			
☐ Dose Titration: ☐ Week 1 & 2: 0.0625 mg (0.25 ml) SQ every other day ☐ Week 5 & 6: 0.1875 mg (0.75 ml) SQ every other day			
☐ Week 3 & 4: 0.125 mg (0.5 ml) SQ every other day ☐ Week 7+: 0.25 mg (1 ml) SQ every other day			
☐ 0.25 mcg (1 ml) SQ every other day			
☐ **Extavia®** ☐ ***Enroll in Extavia Go Program®***			
☐ Dose Titration: ☐ Week 1 & 2: 0.0625 mg (0.25 ml) SQ every other day ☐ Week 5 & 6: 0.1875 mg (0.75 ml) SQ every other day			
☐ Week 3 & 4: 0.125 mg (0.5 ml) SQ every other day ☐ Week 7+: 0.25 mg (1 ml) SQ every other day			
☐ 0.25 mg (1 ml) SQ every other day			
☐ **Novantrone** 2mg/ml multidose vial ☐ 12 mg/ml² (infuse intravenously over 5 to 15 minutes every 3 months)			
☐ **IVIG** ☐ Home infusion ☐ MD's Office Infusion Sig: ______			
☐ **Tysabri** 300mg/15ml -Infuse TYSABRI 300 mg in 100 mL 0.9% Sodium Chloride Injection, USP, over approximately one hour			
☐ **Epipen Autojector** 0.3 mg IMx1, may repeat			
☐ **Epipen Jr** for Peds less than 30kg, 0.15 mg IMx1, may repeat (In the case of anaphylaxis, inject in ante lateral thigh area)			
☐ **Solu-Medrol** 125 mg/2ml Sig: ______			
☐ **Gilenya®**0.5 mg by mouth once daily			
☐ **Assistive devices:** ☐ wheel chairs ☐ bed lifts ☐ Shower chairs ☐ walkers ☐ other______			

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

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

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED ______ REFILLS ______
		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Legal Notice: *This fax transmission may contain confidential information belonging to the sender which is legally privileged. This information is intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the consents of this faxed information is strictly prohibited. Please notify us by phone to arrange for the return of the original documents. This prescription may be filled at a pharmacy of the patient's choice*