



MULTIPLE SCLEROSIS Referral Form

4915 BROADWAY, NEW YORK, NY 10034, TEL: 212-304-4646

FAX: 212-304-0759, Toll Free Number: 1-844-295-8203,

Email: inwoodpharma@gmail.com, Web: www.inwoodpharmacy.com

PATIENT INFORMATION

Patients Name :		SSN#:		DOB:	
Address:		City:	State:	Zip:	
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male	Female
Email Address:		Diagnosis Code:			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxD:	Phone:
Secondary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxD:	Phone:

DIAGNOSIS/CLINICAL INFORMATION (Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization)

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): _____ 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: _____ Infection training completed by: Any MRI changes? 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 Creatine _____ Creatinine Clearance _____
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PRESCRIPTION INFORMATION (or attach copy of your prescription)

MEDICATION	DOSE / STRENGTH	Sig	Qty	Refills
Avonex	30mcg Prefilled Syringe #4 30mcg Pen #4	Inject 30mcg IM once weekly	4week supply	
Betaseron	0.3mg vial	Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD Maintenance Dose: 0.25mg/1ml subcutaneously QOD Other:	4 week supply	
Copaxone	20mg Prefilled Syringe	20mg SQ QD	4 week supply	
Extavia	0.3mg vial	Maintenance Dose: 0.25mg/1ml subcutaneously QOD Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD Other:	4 week supply	
Gilenya	0.5mg capsule	Take 0.5mg po QD	4 week supply	
Rebif Rebif Redidose	Titration Pack (8.8mcg/22mcg) 22mcg Prefilled Syringe 44mcg Prefilled Syringe	Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) Maintenance: Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) Maintenance: Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) Other:	4 week supply	

Prescriber Name:	Phone:	Fax:
Office Address:	Email:	NPI#:
DEA#:	LIC#:	<input type="checkbox"/> Dispense as written: _____ Date
Prescriber Signature :	Deliver To :	<input type="checkbox"/> M D Office <input type="checkbox"/> Patient Home

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed Medications. We will also pursue available copay and financial assistance on behalf of your patients.