Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

MS Prescription Referral Form

Send your Rx to:

avella.com
If you have questions or concerns, please contact us.

Date Medication Needed: ______ **Ship To:** Patient's Home Prescriber's Office Pick-up (store location): ______ 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#:** ______ **Tax ID#:** ______

Address: ______ **Phone:** ______ **Fax:** ______

City, State, Zip: ______ **Key Contact:** ______ **Phone:** ______

3: 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): ______

Will patient be stoping 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

Inection training completed by:

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** ______

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Avonex®	AVOSTARTGRIP Titration Kit 30mcg Prefilled Syringe #4 30mcg Pen #4	**Dose Titration:** • Week 1: Inject 7.5mcg IM once weekly • Week 2: Inject 15mcg IM once weekly • Week 3: Inject 22.5mcg IM once weekly • Week 4+: Inject 30mcg IM once weekly Inject 30mcg IM once weekly	4 week supply	0 -------------
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	0 -------------
Copaxone®	20mg Prefiled Syringe 40mg Prefiled Syringe	20mg SQ QD 40 mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week	4 week supply	
Extavia®	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	0 -------------
Glatopa®	20mg Prefiled Syringe	20mg SQ QD	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	0 -------------

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 Permissable ______ Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: ______

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