BARNERT PHARMACY

"FAST, FRIENDLY, DEPENDABLE SERVICE"

MULTIPLE SCLEROSIS REFERRAL FORM

680 Broadway Suite 108
Paterson, NJ 07514

• (P) 973.925.7200 • BarnertPharmacy.com • (F) 973.925.7202

Patient Information

Patient Name ____________________ Today's Date __________ ☐ *NEW Patient* ☐ *CURRENT Patient*

DOB __________ Height __________ Weight __________ ☐ Male ☐ Female Preferred Language __________

Best Phone ____________________ Email ____________________

Street Address ____________________ Apt# ________ City __________ State __________ Zip __________

Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address

Allergies ____________________

Current Medications including OTC's (*please fax a complete list*) ____________________

Please Fax Insurance Card(s) both sides

Insured's Name ____________________

Relation to Patient ____________________

Primary Insurance ____________________

ID# __________ Group# __________

Secondary Insurance ____________________

ID# __________ Group# __________

Ordering Prescriber

Office Contact ____________________

Street Address ____________________ Suite # __________

City __________ State __________ Zip __________

Tel __________ Fax __________

Email ____________________

License# ____________________

NPI# ____________________

ICD-10 Code ☐ **G35** Multiple Sclerosis Date of Diagnosis: __________ Date of 1st demyelinating event: __________

☐**Yes** ☐ **No** Previously Treated for this condition? Medications Failed ____________________

☐**Yes** ☐ **No** Is Patient currently on therapy? Type/Medication(s) ____________________

☐**Yes** ☐ **No** Will Patient stop taking the medication(s) before starting new medication?

If yes, how long should Patient wait before starting new medication? ____________________

Date of next blood work ____________________

Type: ☐ Relapsing-Remitting ☐ Primary Progressive ☐ Clinically Isolated Syndrome (CIS)
☐ Progressive-relapsing ☐ Secondary progressive with relapses ☐ Secondary progressive without relapses

Prescription

☐ **AVONEX ADMINISTRATION PACK 30 mcg** ☐ **PFS** ☐ **Single Dose Vial** ☐ **Single Dose Avonex Pen**

SIG: ☐ Inject 30 mcg IM once weekly QTY: # ________ Weeks (1 pack = 4 week supply) Refill: ________
☐ Other ____________________ QTY: # ________ Weeks (1 pack = 4 week supply) Refill: ________

☐ **BETASERON 0.3mg Vials**

SIG: ☐ Inject ______ subcutaneously every other day QTY: # ________ Weeks (1 box = 4 week supply) Refill: ________
☐ Other ____________________ QTY: # ________ Weeks (1 box = 4 week supply) Refill: ________

☐ **COPAXONE** *(Glatiramer Acetate)*

☐ **40 mg/ml Syringe** SIG: ☐ Inject 40 mg subcutaneously 3 times weekly QTY: # ________ Syringes Refill: ________
☐ Other ____________________ QTY: # ________ Syringes Refill: ________

☐ **20 mg/ml Syringe** SIG: ☐ Inject 20 mg subcutaneously once daily QTY: # ________ Syringes Refill: ________
☐ Other ____________________ QTY: # ________ Syringes Refill: ________

☐ **EXTAVIA VIALS**

SIG: ☐ Inject ______ subcutaneously every other day QTY: # ________ Weeks (1 box = 4 week supply) Refill: ________
☐ Other ____________________ QTY: # ________ Weeks (1 box = 4 week supply) Refill: ________

☐ **GILENYA 0.5 mg capsule** SIG: ☐ Take one capsule by mouth once daily QTY: 28 Refill: ________

☐ **REBIF TITRATION PACK** ☐ **Prefilled Syringes** ☐ **Rebidose Prefilled Pens**

SIG: ☐ Inject 8.8 mcg subcutaneously TIW - weeks 1 & 2
☐ Inject 22 mcg subcutaneously TIW - weeks 3 & 4 *Maintenance Dose following week 3 & 4*
QTY: # ________ Boxes (1 box = 4 week supply) Refill: ________

☐ **REBIF 22 mcg/0.5ml** (48hrs apart) ☐ **Prefilled Syringes** ☐ **Rebidose Prefilled Pens**

SIG: ☐ Inject 22 mg (0.5ml) subcutaneously TIW QTY: # ________ Boxes (1 box = 4 week supply) Refill: ________

☐ **REBIF 44 mcg/0.5ml (maintenance)** (48hrs apart) ☐ **Prefilled Syringes** ☐ **Rebidose Prefilled Pens**

SIG: ☐ Starting week 5: 44 mcg (0.5ml) subcutaneously TIW QTY: # ________ Boxes (1 box = 4 week supply) Refill: ________

☐ **OTHER** ____________________ QTY: # ________ Boxes (1 box = 4 week supply) Refill: ________

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

By signing this form I authorize Barnert Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

__________ **Prescriber's signature** (no stamps) if brand required check this ☐ DAW____ **Date** __________