MULTIPLE SCLEROSIS REFERRAL FORM

Date: _____

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN:_____ Group: _____

DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

Primary Diagnosis: _____ **Laboratory Results**: LEVF _____ **Date**: _____ **Platelets**: _____ **Date**: _____

ANC: _____ **Date**: _____ **Bilirubin**: _____mg/dL **Date**: _____ **Allergies:** _____

Pregnancy Test: _____(+/-) **Date**: _____ **Concurrent Meds**: _____

Expected Date of First/Next Injection: _____ **Date of Last Injection (if applicable):** _____

Aubagio (teriflunomide)

☐ **7 mg** ☐ **14 mg**
SIG: ☐ Take one 7mg tablet orally once daily
☐ Take one 14mg tablet orally once daily
QTY: ☐ 28-day supply (1 box)
☐ 84-day supply (3 boxes)
Refills: _____

Copaxone (glatiramer acetate)

☐ **20 mg PFS** ☐ **40 mg PFS**
SIG: ☐ Inject 20mg subcutaneously daily
☐ Inject 40mg subcutaneously three times per week
☐ Autoject 2
QTY: 20mg: ☐ 30-day supply ☐ 90-day supply
40mg: ☐ 28-day supply ☐ 84-day supply
Refills: _____

Mitoxantrone HCL

☐ **20mg MDV** ☐ **25mg MDV** ☐ **30mg MDV**
SIG: ☐ Dilute and administer 12mg/m^2 as IV infusion every 3 months
QTY: _____ Refills: _____

Glatiramer acetate

☐ **20 mg PFS**
SIG: ☐ Inject 20 mg subcutaneously daily
QTY: ☐ 30-day supply ☐ 90-day supply
Refills: _____

Avonex (interferon beta-1a)

☐ **30 mcg PFS** ☐ **30 mcg single dose vl.**
☐ **30 mcg Avonex Pen (single dose)**
SIG: ☐ Inject 30mcg intramuscularly once weekly
☐ Dose Titration: Week 1 – inject 7.5mcg IM; Week 2 – inject 15mcg IM; Week 3 – inject 22.5mcg IM; Week 4+ - inject 30mcg IM
QTY: ☐ 4-week supply (1 kit)
☐ 12-week supply (3 kits)
Refills: _____

Extavia (interferon beta-1b)

☐ **0.3 mg vial**
SIG: ☐ Inject 0.25mg/1mL subcutaneously every other day
☐ Dose Titration: Weeks 1-2 – inject 0.0625mg/0.25mL; Weeks 3-4 – inject 0.125mg/0.50mL; Weeks 5-6 – inject 0.1875mg/0.75mL; Weeks 7+ -- inject 0.25mg/1mL
QTY: ☐ 30-day supply (1 kit)
☐ 90-day supply (3 kits)
Refills: _____

Tysabri

Tysabri is available through the Biogen TOUCH Prescribing Program. Please call (800) 456-2255.

Betaseron

☐ **0.3 mg vial**
SIG: ☐ Inject 0.25mg (1 mL) sub-c every other day
☐ Dose Titration: Weeks 1-2 – inject 0.0625mg/0.25mL; Weeks 3-4 – inject 0.125mg/0.50mL; Weeks 5-6 – inject 0.1875mg/0.75mL; Weeks 7+ -- inject 0.25mg/1mL
QTY: ☐ 28-day supply (1 kit/14 vials)
☐ 84-day supply (3 kits/42 vials)
Refills: _____

Rebif (interferon beta-1a)

☐ **0.3 mg vial**
SIG: ☐ Inject 0.25mg (1 mL) sub-c every other day
☐ Dose Titration: Weeks 1-2 – inject 0.0625mg/0.25mL; Weeks 3-4 – inject 0.125mg/0.50mL; Weeks 5-6 – inject 0.1875mg/0.75mL; Weeks 7+ -- inject 0.25mg/1mL
QTY: ☐ 28-day supply (1 kit/14 vials)
☐ 84-day supply (3 kits/42 vials)
Refills: _____

Other/Notes:_____
_____
_____
_____
_____
_____

Prescriber Signature: _____ **DAW (Dispense as Written)** **Date:** _____

If Century Specialty Script is the patient's choice, please Call-in, Fax, or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353