EL NORTE
Retail & Specialty Pharmacy

MULTIPLE SCLEROSIS REFERRAL FORM

Phone: (760) 233-2100
Fax: (760-233-2105

Ship To: ❑ Patient ❑ Physician / Clinic ❑ Pick Up ❑ Date Needed: _________ **Injection Training Needed:** ❑ Yes ❑ No

PATIENT INFORMATION				PRESCRIBER INFORMATION	
Patient Name				Prescriber Name	
Address				NPI	
City, State, Zip				Address	
Primary Phone		Alt. Phone		City, State, Zip	
Date of Birth		Allergies		Office Phone:	
Height/ Weight		Sex:	❑ Male ❑ Female	Office Fax:	
Insurance	PLEASE FAX A COPY OF INSURANCE CARD(S)			Contact Person	

CLINICAL INFORMATION

Diagnosis: ❑ Multiple Sclerosis ICD10 Code: _________ ❑ Other: _______________ **Relapsing Form**: ❑ Yes ❑ No ❑ Specify Type: __________________________

Number of Relapses in Past Year: _________ **Date of Diagnosis**: ___________ **Date of Last MRI**: _______________

Tried/Failed Previous Therapies: Prior Therapy: ❑ Yes: Specify: ______________________________________ **Reason for Discontinuation**: ________________________
❑ No If no, please explain why: ________________________

PRESCRIPTION INFORMATION

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **AUBAGIO**	❑ 7mg tablet ❑ 14mg tablet	❑ Take 1 tablet by mouth once daily		
❑ **AVONEX**	❑ 30 mg PEN ❑ 30 mg SYRINGE ❑ 30 mg VIAL	❑ Inject 30mcg intramuscularly once weekly		
❑ **BETASERON**	❑ 0.3 mg vial & diluent	❑ Inject 0.25mg (1mL) subcutaneously every other day ❑ Dose Titration: Weeks 1 -2: Inject 0.0625 mg (0.25mL) SQ QOD Weeks 3-4: Inject 0.125 mg (0.50mL) SQ QOD Weeks 5-6: Inject 0.1875 mg (0.75mL) SQ QOD ❑ Other: ____		
❑ **COPAXONE**	❑ 20 mg syringe	❑ Inject 20mg subcutaneously daily		
	❑ 40 mg syringe	❑ Inject 40mg subcutaneously three times a week		
❑ **EXTAVIA**	❑ 0.3 mg vial & diluent	❑ Inject 0.25mg (1ML) subcutaneously every other day ❑ Dose Titration: Weeks 1 -2: Inject 0.0625 mg (0.25mL) SQ QOD Weeks 3-4: Inject 0.125 mg (0.50mL) SQ QOD Weeks 5-6: Inject 0.1875 mg (0.75mL) SQ QOD ❑ Other: ____		
❑ **GILENYA**	❑ 0.5 mg capsules	❑ Take 1 capsule by mouth once daily		
❑ **GLATOPA**	❑ 20 mg syringe	❑ Inject 20mg subcutaneously daily		
❑ **PLEGRIDY**	❑ Pen Starter Pack ❑ Prefilled Syringe Starter Pack ❑125 mcg pen ❑125 mcg prefilled syringe	❑ Titration Dose: Inject 63mcg SQ day 1 then 94mcg day 15 ❑ Inject 125mcg subcutaneously once every 2 weeks		
❑ **REBIF**	❑ Titration Pack ❑ 22mcg syringe ❑ 44 mcg syringe ❑ Rebidose Auto Injector Titration ❑ Rebidose Auto-Injector 22mcg ❑ Rebidose Auto-Injector 44mcg	❑ Inject ______ subcutaneously three times a week ❑ Inject 8.8mcg SQ three times a week for weeks 1-2 and then 22mcg SQ three times a week for weeks 3-4		
❑ **TECFIDERA**	❑ 30-day Starter Pack ❑ 120mg capsule ❑ 240mg capsule	❑ Titration: Dose: Take 120mg capsule twice daily for 7 days, followed by 240mg twice daily ❑ Take 240 mg by mouth twice daily		
❑ **OTHER**	❑			

By signing below, I authorize El Norte Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient to apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: ____ Date: ____________________________________

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