

MULTIPLE SCLEROSIS REFERRAL FORM

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Patient Information

Patient Name: _____ DOB: _____ Sex: M F
 Phone: _____ Cell Phone: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 ICD-10 Diagnosis Code: _____ Diagnosis: _____
 Allergies (please note reaction): _____ Latex
 Current Medications: (list here or attach a medication list): _____
 Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Avonex (interferon beta-1a)	<input type="checkbox"/> 30mcg Pen <input type="checkbox"/> 30mcg Prefilled Syringe <input type="checkbox"/> 30mcg Single Dose Vial	Inject 30 mcg intramuscularly once a week.	28-day supply	
<input type="checkbox"/> Betaseron (interferon beta-1b)	0.3 mg Kit (contains 14 units)	<input type="checkbox"/> Loading Dose: Inject 0.0625 mg (0.25mL) subcutaneously every other day for weeks 1 and 2, then inject 0.125 (0.5mL) every other day for weeks 3 and 4, then inject 0.1875mg (0.75mL) every other day for weeks 5 and 6, then inject 0.25mg (1mL) every other day for week 7 and thereafter.	56-day supply	
		<input type="checkbox"/> Maintenance Dose: Inject 0.25mg (1mL) subcutaneously every other day.	28-day supply	
		<input type="checkbox"/> Other:		
<input type="checkbox"/> Copaxone (glatiramer acetate)	<input type="checkbox"/> 20mg/mL Prefilled Syringe (1 kit = 30 syringes)	Inject 20mg subcutaneously once daily.	1 kit	
	<input type="checkbox"/> 40mg/mL Prefilled Syringe (1 kit = 12 syringes)	Inject 40mg subcutaneously 3 times per week, at least 48 hours apart.	1 kit	
<input type="checkbox"/> Extavia (interferon beta-1b)	0.3mg Kit (contains 15 units)	<input type="checkbox"/> Loading Dose: Inject 0.0625 mg (0.25mL) subcutaneously every other day for weeks 1 and 2, then inject 0.125 (0.5mL) every other day for weeks 3 and 4, then inject 0.1875mg (0.75mL) every other day for weeks 5 and 6, then inject 0.25mg (1mL) every other day for week 7 and thereafter.	30-day supply	
		<input type="checkbox"/> Maintenance Dose: Inject 0.25mg (1mL) subcutaneously every other day.	30-day supply	
		<input type="checkbox"/> Other:		
<input type="checkbox"/> Gilenya (fingolimod)	0.5mg Capsule	Take 1 capsule by mouth once daily.	30-day supply	
<input type="checkbox"/> Glatopa (glatiramer acetate)	<input type="checkbox"/> 20mg/mL Prefilled Syringe (1 kit = 30 syringes)	Inject 20mg subcutaneously once daily.	1 kit	
<input type="checkbox"/> Novantrone (mitoxantrone)	<input type="checkbox"/> 20mg/10mL (10mL) Concentrate	<input type="checkbox"/> Dilute and administer 12mg/m ² via intravenous infusion (over 5 to 15 minutes every 3 months. Body surface area _____ m ² (or m squared))	84-day supply	
	<input type="checkbox"/> 25mg/12.5mL (12.5mL) Concentrate	<input type="checkbox"/> Other:		
	<input type="checkbox"/> 30mg/15mL (15mL) Concentrate			

Prescription information continued on next page

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Rebif (interferon beta-1a)	<input type="checkbox"/> Titration Pack (six 8.8mcg and six 22mcg prefilled syringes)	<input type="checkbox"/> Loading Dose (44mcg target): Inject 8.8mcg subcutaneously three times weekly for weeks 1 and 2, then inject 22mcg three times weekly thereafter. Doses should be separated by at least 48 hours. <input type="checkbox"/> Loading Dose (22mcg target): Inject 4.4mcg subcutaneously three times weekly for weeks 1 and 2, then inject 11mcg three times weekly for weeks 3 and 4, then inject 22mcg three times weekly thereafter. Doses should be separated by at least 48 hours.	1 kit	
	<input type="checkbox"/> 44mcg/0.5mL Prefilled Syringe <input type="checkbox"/> 22mcg/0.5mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 44mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. <input type="checkbox"/> Maintenance Dose: Inject 22mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. <input type="checkbox"/> Other:	28-day supply	
<input type="checkbox"/> Rebif Rebidose (interferon beta-1a)	<input type="checkbox"/> Titration Pack (six 8.8mcg and six 22mcg autoinjectors) *for 44mcg target dose only*	<input type="checkbox"/> Loading Dose (44mcg target): Inject 8.8mcg subcutaneously three times weekly for weeks 1 and 2, then inject 22mcg three times weekly for weeks 3 and 4, then inject 44mcg three times weekly thereafter. Doses should be separated by at least 48 hours.	1 kit	
	<input type="checkbox"/> 44mcg/0.5mL Autoinjector <input type="checkbox"/> 22mcg/0.5mL Autoinjector	<input type="checkbox"/> Maintenance Dose: Inject 44mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. <input type="checkbox"/> Maintenance Dose: Inject 22mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. <input type="checkbox"/> Other:	28-day supply	
<input type="checkbox"/> Tysabri (natalizumab)	300mg/15mL Concentrate	Administer 300mg via intravenous infusion over 1 hour every 4 weeks.	28-day supply	
Other Medication Name:				

Treatment History: **New to Therapy** **Continuation of Therapy**

Is patient pregnant, nursing or planning pregnancy? Yes No N/A

Novantrone: Is patient's LVEF less than 50%? Yes No

Is patient using prescribed therapy in combination with other biologics for MS? Yes No

Patient's lifetime (cumulative) Novantrone dose: _____ mg/m²

Please attach the latest copy of CBC with differential.

Prescriber Name: _____
 State License #: _____ DEA #: _____ NPI: _____
 Additional Contact Person Name: _____
 Group or Hospital: _____ Phone: _____
 Fax: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Prescriber Signature: _____

Product Substitution Permitted

Date

Dispensed as Written

Date

Ship to: Patient Prescriber/Clinic

Pick up at an Albertsons Companies Pharmacy

Address: _____

Phone: _____

Date Medication Needed: _____