MULTIPLE SCLEROSIS REFERRAL FORM A-C

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

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): _____

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Avonex (interferon beta-1a)	☐ AvoStartGrip Titration Kit ☐ 30mcg Pen ☐ 30mcg Prefilled Syringe ☐ 30mcg Single Dose Vial	☐ Loading dose: Inject 7.5mcg IM once weekly for one week. Then inject 15mcg IM once weekly for week 2. Then inject 22.5mcg IM once weekly for week 3. Then inject 30mcg IM once weekly and thereafter. ☐ Inject 30mcg intramuscularly once a week.	☐ 1 titration kit (3 syringes) ☐ 4 syringes/ vials/pens ☐ ___syringes/ vials/pens	
☐ Betaseron (interferon beta-1b)	0.3 mg Kit (contains 14 vials)	☐ Loading Dose: Inject 0.0625mg (0.25mL) subcutaneously every other day for weeks 1 and 2, then inject 0.125mg (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.	28 vials	
		☐ Maintenance Dose: Inject 0.25mg (1mL) subcutaneously every other day.	14 vials	
		☐ Other:		
☐ Copaxone (glatiramer acetate)	☐ 20mg/mL Prefilled Syringe (1 kit = 30 syringes)	Inject 20mg subcutaneously once daily.	30 syringes	
	☐ 40mg/mL Prefilled Syringe (1 kit = 12 syringes)	Inject 40mg subcutaneously 3 times per week, at least 48 hours apart.	12 syringes	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

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

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

Prescriber Information

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 | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

MULTIPLE SCLEROSIS REFERRAL FORM D-G

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

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): _____

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Extavia (interferon beta-1b)	0.3mg Kit (contains 15 vials)	☐ Loading Dose: Inject 0.0625mg (0.25mL) subcutaneously every other day for weeks 1 and 2, then inject 0.125mg (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 vials	
		☐ Maintenance Dose: Inject 0.25mg (1mL) subcutaneously every other day.	15 vials	
		☐ Other:		
☐ Gilenya (fingolimod)	0.5mg Capsule	Take 1 capsule by mouth once daily.	30 capsules	
☐ Glatopa (glatiramer acetate)	☐ 20mg/mL Prefilled Syringe (1 kit = 30 syringes)	Inject 20mg subcutaneously once daily.	30 syringes	
	☐ 40mg/mL Prefilled Syringe (1 kit = 12 syringes)	Inject 40mg subcutaneously 3 times per week, at least 48 hours apart.	12 syringes	
☐ Novantrone (mitoxantrone)	☐ 20mg/10mL (10mL) Concentrate ☐ 25mg/12.5mL (12.5mL) Concentrate ☐ 30mg/15mL (15mL) Concentrate	☐ Dilute and administer 12mg/m² via intravenous infusion (over 5 to 15 minutes every 3 months. Body surface area _____m2 (or m squared)	_____ vials	
		☐ Other:		

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Is patient pregnant, nursing or planning pregnancy? ☐ Yes ☐ No ☐ N/A
Is patient using prescribed therapy in combination with other biologics for MS? ☐ Yes ☐ No

Novantrone: Is patient's LVEF less than 50%? ☐ Yes ☐ No
Patient's lifetime (cumulative) Novantrone dose: _____mg/m²
Please attach the latest copy of CBC with differential.

Prescriber Information

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 | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

MULTIPLE SCLEROSIS REFERRAL FORM H-R

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

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): _____

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Rebif (interferon beta-1a)	☐ Titration Pack (six 8.8mcg and six 22mcg prefilled syringes)	☐ 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. ☐ 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.	12 syringes	
	☐ 44mcg/0.5mL Prefilled Syringe ☐ 22mcg/0.5mL Prefilled Syringe	☐ Maintenance Dose: Inject 44mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. ☐ Maintenance Dose: Inject 22mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. ☐ Other:	12 syringes	
☐ Rebif Rebidose (interferon beta-1a)	☐ Titration Pack (six 8.8mcg and six 22mcg autoinjectors) *for 44mcg target dose only*	☐ 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.	12 syringes	
	☐ 44mcg/0.5mL Autoinjector ☐ 22mcg/0.5mL Autoinjector	☐ Maintenance Dose: Inject 44mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. ☐ Maintenance Dose: Inject 22mcg subcutaneously three times weekly. Doses should be separated by at least 48 hours. ☐ Other:	12 syringes/ autoinjectors	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

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

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

Prescriber Information

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 | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

MULTIPLE SCLEROSIS REFERRAL FORM S-Z

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

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): _____

Prescription Information

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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Tysabri (natalizumab)	300mg/15mL Concentrate	Administer 300mg via intravenous infusion over 1 hour every 4 weeks.	☐ 1 vial ☐ ____ vials	
Other Medication Name:				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

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

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

Prescriber Information

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 | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____