MULTIPLE SCLEROSIS PRESCRIPTION REFERRAL FORM

REALO SPECIALTY CARE PHARMACY

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: ____ ❑Male ❑Female SS#: ____ DOB: ____
Address: ____ City, State, Zip: ____
Primary Phone: ____ ❑Home ❑Cell ❑Work Alternate Phone: ____ ❑Home ❑Cell ❑Work
Email: ____ Height: ____ Weight: ____
Allergies: ____ Comorbidities: ____

PRESCRIBER INFORMATION

Prescriber Name: ____ Office Contact: ____
Address: ____ City, State, Zip: ____
Phone: ____ Fax: ____
NPI: ____ DEA: ____

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: ____
Date Shipment Needed By: ____ ❑Alternate Location: ____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Primary ICD-9 Code: 340 Secondary ICD-9 Code: ____ Date of first demyelinating event: ____
Type: ❑Clinically isolated syndrome ❑Relapsing-remitting ❑Secondary-progressive ❑Primary-progressive ❑Progressive-relapsing
BMD/T-score: ____ Date: ____ Is patient new to therapy? ❑yes ❑no
Please provide clinical rationale for prescribing this agent (if not preferred formulary agent): ____
Prior therapies: ____
Reason for discontinuation: ____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
❑Betaseron®	❑0.3 mg vial	❑Dose Titration: Week 1-2: Inject 0.0625 mg (0.25 mL) subq every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subq every other day; Week 5-6: Inject 0.1875 mg (0.75 mL) subq every other day; Week 7-8: Inject 0.25 mg (1 mL) subq every other day.	❑4 week supply	
		❑Maintenance Dose: Inject 0.25 mg (1 mL) subq every other day	❑4 week supply	
❑Copaxone®		❑20 mg subq once daily	❑30 mL	
		❑40 mg subq 3 times per week administered at least 48 hours apart	❑12 mL	
❑Dalfampridine	❑10 mg	❑Take 10 mg by mouth twice a day, approximately 12 hours apart	❑60	
❑Extavia®	❑0.3 mg vial	❑Dose Titration: Week 1-2: Inject 0.0625 mg (0.25 mL) subq every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subq every other day; Week 5-6: Inject 0.1875 mg (0.75 mL) subq every other day; Week 7-8: Inject 0.25 mg (1 mL) subq every other day.	❑4 week supply	
		❑Inject 0.25 mg (1 mL) subq every other day	❑4 week supply	
❑Gilenya®	❑0.5 mg	❑Take one capsule by mouth once daily	❑1 box (28 capsules)	
		❑Other:	❑1 bottle (30 capsules)	
❑Glatiramer Acetate		❑Inject 20 mg subq once daily	❑30 mL	
		❑Inject 40 mg subq three times per week at least 48 hours apart	❑12 mL	
❑Glatopa™		❑Inject 20 mg subq once daily	❑30 mL	
		❑Inject 40 mg subq three times per week at least 48 hours apart	❑12 mL	
❑Ocrevus™	❑300 mg/10 mL	❑Infuse 300 mg intravenously over no less than 2.5 hours on day and day 15	❑2	
		❑Infuse 600 mg intravenously over no less than 3.5 hours 6 months after the day 1 infusion and every 6 months thereafter	❑2	
❑Rebif®	❑Titration Pack 4.4mcg/22 mcg	❑Dose Titration: Week 1-2: Inject 4.4 mcg (0.1 mL) subcut three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subcut three times per week.	❑4 week supply	
	❑22 mcg PFS	❑Week 5 and thereafter: Inject 22 mcg subcut three times per week		
	❑Titration Pack 8.8mcg/44 mcg	❑Dose Titration: Week 1-2: Inject 8.8 mcg (0.2 mL) subcut three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subcut three times per week.	❑4 week supply	
	❑44 mcg PFS	❑Week 5 and thereafter: Inject 44 mcg subcut three times per week		

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature | Date | Substitution Permissable - Signature | Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.