# MULTIPLE SCLEROSIS REFERRAL FORM

Date: _____

**SUPERIOR BIOLOGICS**
**Fax Referral To: 914-747-1170**
**Phone: 855-747-1150**

SUPERIOR BIOLOGICS

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: _____

### 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: _____

### 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: _____

### 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: _____

### 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: _____

### 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: _____

### 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: _____

### Tysabri

Tysabri is not available for home infusion. It may be obtained through the Biogen TOUCH Prescribing Program. Please call (800) 456-2255.

**Other/Notes**: _____

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