

**MULTIPLE SCLEROSIS
REFERRAL FORM**

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



Date: _____

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/m² 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:** _____

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