

**MULTIPLE SCLEROSIS  
REFERRAL FORM**

**MIDWEST BIOLOGICS**  
Fax Referral To: 844-237-3562  
Phone: 844-237-3561



Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell 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: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
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<sup>2</sup> 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: \_\_\_\_\_