

Date Shipment Needed:	Ship to : □Patient □Prescriber
□ Nursing needed; □Training needed ►	All the supplies including syringes and needles will be dispensed if needed.

Phone: 1-800-275-0139 • Fax: 843-972-9395

## MULTIPLE SCLEROSIS INJECTABLE AGENTS REFERRAL FORM

Address:   City:   State:   Zip:   Emergency Contact:   Phone:   DEA:   State Lic:   Supervising Physician:   Practice Name:   Address:   City:   State Lic:   Supervising Physician:   Practice Name:   Address:   City:   State:   Zip:   Address:   City:   State:	PATIENT INFORMATIO	N						
City:   Slate:   Zip:   Emargency Contact:   Phone:   Please attach demographic information   Please   Please attach demographic information   Please   Please attach demographic information   Please	Patient Name:			DOB:	Sex: □M □F	Weight:		□ lbs. □kg.
Address:	SSN:	Phone:	Allergies:		Į.			
Pieze   Pieze attach demographic information   Pieze   Pieze attach demographic information   Pieze	Address:			City:	State:	Zij	p:	
Prescriber   NPI:   DEA   State Lic:			Phone:		□ Please a	ttach demogra	aphic information	on
Prescriber:   NPI:   DEA:   State Lic:		ATION					•	
Piraction Name:   Piraction	Prescriber:		NPI:	DEA:		State Lic:		
Phone:     Phone:	Supervising Physician:		<u> </u>	Practice Name:				
DIAGNOSIS INTEGRINATION   MEDICAL ASSESSIBLY	Address:			City:	State:	Zij	ρ:	
Multiple Sciencis (CO-10: 035   Type:   Relapsing remitting   Primary progressive   Secondary progressive relapsing   Other:   Has patient been treated previously for this condition?   Yes   No Previous medication(s):   Is patient currently on therapy?   Yes   No Previous medication(s):   Is patient currently on therapy?   Yes   No Previous medication(s):   Is patient currently on therapy?   Yes   No Previous medication(s):   Is patient currently on therapy?   Yes   No Previous medication(s):   Yes   No.   Yes; How on Should patient water before starting the new medication?   Yes   No.   Yes; How on Should patient water before starting the new medication?   Yes   No.   Yes; How on Should patient water before starting the new medication?   Yes   No.   Yes; How on Should patient water before starting the new medication?   Yes   No.   Yes; How on Should patient water before starting the new medication?   Yes   No.   Yes   Y	Phone:			Key Office Contact	:	Phone:		
Has patient been treated previously for this condition?   res   Mo Previous medication(s):   Is patient currently on therapy?   res   No Current therapy:   Aubagio   Avonex   Baffertam   Betaseron   Copascone   Dimethyl Fumarate   Extavia   Gidenya   Gilatiramer   Acatala Cilatoga Kesimpta   Lentrada   Milavanet   Movantone   Corevous   respect   No. fiyes; Now long should patient with before starting the new medication?   res   No. fiyes; Now long should patient with before starting the new medication?   res   No. fiyes; Now long should patient with before starting the new medication?   res   No. fiyes; Now long should patient with before starting the new medication?   res   Now res   N	DIAGNOSIS INFORMAT	TION / MEDICAL ASSESMENT						
Is patient currently on therapy?   Yes   INX Current therapy.   Caubagio   Calvorack   Clelary   Calvoration   Capacons   Commenting   Cardon   Capacons					☐ Progressive relapsin	ig 🗆 Other:		
Acetate								
Will patient stop taking the above medication(s) before starting the new medication?   Ves.   No. if yes.   No.								iramer
Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):  Patient's medical history includes:   Current pregnancy   Congestive heart failure   Severe hepatic impairment   HIV infection   Other:  PRESCRIPTION INFORMATION    Avonew 30 mmg								
Patients medical history includes:   Current pregnancy   Congestive heart failure   Severe hepatic impairment   HIV infection   Other: Patients (Patients)   Patients (Patients)			-	•	-	ore starting the n	ew medication?	
			_	,				
		, , ,	Congestive heart failure	Severe hepatic impairme	ent   HIV infection	Other:		
Tritation kit: '\ dose IM week 1, '\ dose IM week 2, '\ dose IM week 3, full dose IM week 4   CTY: 28 day   Refilis: O   Pre-  Prefilled syringe   Maintenance directions: 30mg IM once weekly   Refilis: O   Pre-  Prefilled syringe   Maintenance directions: 30mg IM once weekly   Refilis: O   Refilis   Refilis: O   R	PRESCRIPTION INFORI	MATION						
Perfilled syringe   Maintenance directions: 30mg IM once weekly   CPY: 28 day   Refils:   Debasorno®   Betaject Lite®   BetaConnect® Auto Injection	□ Avonex® 30 mcg							
Alternate dosing		,	*					_
Betaseron		☐ Maintenance directions: 30mg IN	I once weekly					
Dose Titration: Week 1 & 2: 0.0625 mg (0.25 mL) SQ every other day, Week 3 & 4: 0.125 mg (0.5 mL) SQ every other day, Week 7 * 0.25 mg (1 mL) SQ every other day   Maintenance Dose: 0.25 mg (1 ml) SQ every other day. Week 7 * 0.25 mg (1 mL) SQ every other day   Alternate Dosing:	-						· · · · · · · · · · · · · · · · · · ·	
Week 5 & 6 : 0.875 mg (0.75 mL) SQ every other day   QTY : 28 day   Refills:     Alternate Dosing:   Copaxone® 20 mg/mL PFS   Copaxone® 40 mg/mL PFS Q GENERIC   Glatiramer Acetate 20 mg/mL PFS   Glatiramer Acetate 40 mg/mL PFS   Copaxone® 20 mg/mL PFS Q GENERIC   Glatiramer Acetate 20 mg/mL PFS   Glatiramer Acetate 40 mg/mL PFS   Copaxone® 20 mg/mL PFS Q General in Shared Solutions®   QTY: 30 day   Refills:     20 mg SQ once daily   QTY: 28 day   Refills:     40 mg SQ three times a week   QTY: 30 day   Refills:     51 Extavia®   QTY: 28 day   Refills:     52 Extavia® Q   Dose Titration: Week 1 & 2: 0.0625 mg (0.25 mL) SQ every other day, Week 3 & 4: 0.125 mg (0.5 mL) SQ every other day   QTY: 28 day   Refills:     52 Extavia® Q   QTY: 30 day   Refills:     40 mg/mL SQ 3 times per week   QTY: 30 day   Refills:     52 Glatopa® 20 mg/mL PFS   Glatopa® 40 mg/mL PFS   Refills:     53 Glatopa® 20 mg/mL SQ 3 times per week   QTY: 30 day   Refills:     54 Kesimpta® 20 mg/mL Sq 0 once weekly at weeks 0, 1, and 2   QTY: 28 day   Refills:     54 Kesimpta® 20 mg/m SQ once weekly at weeks 0, 1, and 2   QTY: 3   Refills:     55 Lestrer: 20 mg SQ once weekly at weeks 0, 1, and 2   QTY: 3   Refills:     55 Lestrer: 20 mg SQ once weekly at weeks 0, 1, and 2   QTY: 3   Refills:     55 Lestrer: 20 mg SQ once weekly at weeks 0, 1, and 2   QTY: 3   Refills:     55 Lestrer: 20 mg SQ once weekly at weeks 0, 1, and 2   QTY: 3   Refills:     55 Lestrer: 20 mg SQ once weekly at weeks 0, 1, and 2   Refills:   QTY: 2   Refills:     55 Lestrer: 20 mg SQ once weekly at weeks 0, 1, and 2   Refills:   QTY: 2   Refills:   QT	☐ Betaseron® ☐ Betaject	Lite® ☐ BetaConnect® Auto Injection	ction				☐ Enroll in Be	eta PlusSM MS
Maintenance Dose: 0.25 mg (1 ml) SQ every other day   Alternate Dosing:   Copaxone® 20 mg/mL PFS   Copaxone® 40 mg/mL PFS OR GENERIC   Glatiramer Acetate 20 mg/mL PFS   Glatiramer Acetate 40 mg/mL PFS   Enroll in Shared Solutions®   Copaxone® 20 mg/mL PFS   Copaxone® 40 mg/mL PFS OR GENERIC   Glatiramer Acetate 20 mg/mL PFS   Glatiramer Acetate 40 mg/mL PFS   Enroll in Shared Solutions®   Copaxone® 20 mg/mL PFS   Copaxone® 40 mg/mL PFS OR GENERIC   Glatiramer Acetate 20 mg/mL PFS   Glatiramer Acetate 40 mg/mL PFS   Enroll in Shared Solutions®   Copaxone® 40 mg/mL PFS   Copaxone® 40 mg/mL					ery other day,		QTY: 28 day	Refills: 1
Alternate Dosing:	Week 5 & 6: 0.875 n	ng (0.75 mL) SQ every other day, W	eek 7+: 0.25 mg (1 mL) SQ e	every other day				
Copaxone® 20 mg/mL PFS   Copaxone® 40 mg/mL PFS OR GENERIC   Glatiramer Acetate 20 mg/mL PFS   Glatiramer Acetate 40 mg/mL PFS   Enroll in Shared Solutions®     20 mg SQ once daily   QTY: 30 day   Refills:     20 mg SQ once daily   Glatiramer Acetate 20 mg/mL PFS   Glatiramer Acetate 40 mg/mL PFS   Glatiramer	☐ Maintenance Dose:	0.25 mg (1 ml) SQ every other day						
20mg SQ once daily   QTY: 30 day   Refills:								
dam g SQ three times a week			S OR GENERIC   Glatiran	ner Acetate 20 mg/mL P	PFS  Glatiramer Aceta	ite 40 mg/mL PF		
Dose Titration: Week 1 & 2: 0.0625 mg (0.25 mL) SQ every other day, Week 3 & 4: 0.125 mg (0.5 mL) SQ every other day Week 5 & 6: 0.1875 mg (0.75 mL) SQ every other day, Week 7 +: 0.25 mg (1 mL) SQ every other day Maintenance Dose: 0.25 mg (1 mL) SQ every other day Alternate Dosing:    Glatopa® 20mg/mL PFS	-							
Dose Titration: Week 1 & 2: 0.0625 mg (0.25 mL) SQ every other day, Week 3 & 4: 0.125 mg (0.5 mL) SQ every other day   Week 5 & 6: 0.1875 mg (0.75 mL) SQ every other day, Week 7+: 0.25 mg (1 mL) SQ every other day   Maintenance Dose: 0.25 mg (1 mL) SQ every other day   Alternate Dosing:		s a week						
Week 5 & 6: 0.1875 mg (0.75 mL) SQ every other day, Week 7+: 0.25 mg (1 mL) SQ every other day    Maintenance Dose: 0.25 mg (1 mL) SQ every other day   Alternate Dosing:				405 (0.5.1).00				
Maintenance Dose: 0.25 mg (1 mL) SQ every other day Alternate Dosing:   QTY: 30 day Refills:   QTY:   Refills:   QTY: 30 day Packers   QTY: 28 day Pack					ery other day		Q11: <u>28 day</u>	Refills: 1
Alternate Dosing:   Clatopa® 20mg/mL PFS   Glatopa ® 40 mg/mL SQ 3 times per week   QTY: 30 day   Refills:   QTY: 28 day   Refills:   QTY: 28 day   Refills:   QTY: 28 day   Refills:   QTY: 28 day   Refills:   QTY: 30 mg/mL PFS   Glatopa ® 40 mg/mL SQ 3 times per week   QTY: 30 mg/mS 20 mg			a day, week /+. 0.25 mg (1)	nic) SQ every officer day			OTV: 30 day	Refills:
Glatopa® 20mg/mL PFS		o.25 mg (1 mz) od every other day						
20 mg SQ every day		☐ Glatopa ® 40 mg/mL PFS						
Alternate Dosing:								•
Kesimpta® 20mg/0.4mL single-dose	☐ 40 mg/mL SQ 3 time	es per week					QTY: 28 day	Refills:
Starter: 20mg SQ once weekly at weeks 0, 1, and 2  ☐ Maintenance: 20mg sq once monthly starting at week 4  ☐ Lemtrada® 12 mg/0.5 mL * Patient must be enrolled in Lemtrada REMS. Please fax completed Prescription Ordering form and Lemtrada REMS patient nrollment form to Lemtrada REMS at 1.855.557.2478. Infused at Infusion Centers registered in Lemtrada REMS program. Call 855.676.6326 with questions.  ☐ Ocrevus® 300mg/10mL Single Dose vial  ☐ Starter: 300mg IV on day 1, and day 15  ☐ Maintenance: 600mg IV every 6 months  ☐ Plegridy® 125 mcg/0.5 mL ☐ Plegridy Starter Pack ☐ Pen ☐ Prefilled Syringe  ☐ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15  ☐ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days  ☐ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days	☐ Alternate Dosing:						QTY:	Refills:
□ Maintenance: 20mg sq once monthly starting at week 4 QTY: Refills:   □ Lemtrada® 12 mg/0.5 mL * Patient must be enrolled in Lemtrada REMS. Please fax completed Prescription Ordering form and Lemtrada REMS patient nrollment form to Lemtrada REMS at 1.855.557.2478. Infused at Infusion Centers registered in Lemtrada REMS program. Call 855.676.6326 with questions.   □ Ocrevus® 300mg/10mL Single Dose vial QTY: _2 Refills: _0   □ Starter: 300mg IV on day 1, and day 15 QTY: _2 Refills: _0   □ Maintenance: 600mg IV every 6 months QTY: _2 Refills: _0   □ Plegridy® 125 mcg/0.5 mL □ Plegridy Starter Pack □ Pen □ Prefilled Syringe □ Enroll in Above MS™   □ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15 QTY: _28 day Refills: _0   □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days QTY: _28 day Refills: _0	□ Kesimpta® 20mg/0.4mL	single-dose	□ Prefilled Syringe					
□ Maintenance: 20mg sq once monthly starting at week 4 QTY: Refills:   □ Lemtrada® 12 mg/0.5 mL * Patient must be enrolled in Lemtrada REMS. Please fax completed Prescription Ordering form and Lemtrada REMS patient nrollment form to Lemtrada REMS at 1.855.557.2478. Infused at Infusion Centers registered in Lemtrada REMS program. Call 855.676.6326 with questions.   □ Ocrevus® 300mg/10mL Single Dose vial QTY: _2 Refills: _0   □ Starter: 300mg IV on day 1, and day 15 Maintenance: 600mg IV every 6 months QTY: _2 Refills: _0   □ Plegridy® 125 mcg/0.5 mL □ Plegridy Starter Pack □ Pen □ Prefilled Syringe Enroll in Above MS™ □ Enroll in Above MS™   □ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15 QTY: _28 day Refills: _0   □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days QTY: _28 day Refills:	☐ Starter: 20mg SQ or	nce weekly at weeks 0. 1. and 2					QTY: 3	Refills: 0
□ Lemtrada® 12 mg/0.5 mL * Patient must be enrolled in Lemtrada REMS. Please fax completed Prescription Ordering form and Lemtrada REMS patient nrollment form to Lemtrada REMS at 1.855.557.2478. Infused at Infusion Centers registered in Lemtrada REMS program. Call 855.676.6326 with questions.  □ Ocrevus® 300mg/10mL Single Dose vial □ Starter: 300mg IV on day 1, and day 15 □ Maintenance: 600mg IV every 6 months □ Plegridy® 125 mcg/0.5 mL □ Plegridy Starter Pack □ Pen □ Prefilled Syringe □ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15 □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days	-							
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□ Starter: 300mg IV on day 1, and day 15       QTY: _2 Refills: _0         □ Maintenance: 600mg IV every 6 months       QTY: _2 Refills:         □ Plegridy® 125 mcg/0.5 mL □ Plegridy Starter Pack □ Pen □ Prefilled Syringe       □ Enroll in Above MS™         □ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15       QTY: 28 day       Refills: _0         □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days       QTY: 28 day       Refills:								
□ Maintenance: 600mg IV every 6 months       QTY: _2 Refills:         □ Plegridy® 125 mcg/0.5 mL □Plegridy Starter Pack □ Prefilled Syringe       □ Enroll in Above MS™         □ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15       QTY: 28 day       Refills: _0         □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days       QTY: 28 day       Refills:	☐ Ocrevus® 300mg/10mL	Single Dose vial						
□ Maintenance: 600mg IV every 6 months       QTY: _2 Refills:         □ Plegridy® 125 mcg/0.5 mL □ Plegridy Starter Pack □ Pen □ Prefilled Syringe       □ Enroll in Above MS™         □ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15       QTY: 28 day       Refills: _0         □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days       QTY: 28 day       Refills:	☐ Starter: 300mg IV on	day 1, and day 15					QTY: 2	Refills: 0
□ Plegridy® 125 mcg/0.5 mL       □ Plegridy Starter Pack       □ Prefilled Syringe       □ Enroll in Above MS™         □ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15       QTY: 28 day       Refills: 0         □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days       QTY: 28 day       Refills:	-							
□ Dose Titration: 63 mcg (orange) SQ on day 1, then 94 mcg (blue) SQ on day 15 □ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days  QTY: 28 day  Refills: 0  Refills:	-	•	Prefilled Syringe					
☐ Maintenance Dose: 125 mcg (0.5 mL) SQ every 14 days QTY: 28 day Refills:								
□ Alternate Dosing: QTY: Refills:	☐ Maintenance Dose: 1	125 mcg (0.5 mL) SQ every 14 days					QTY: 28 day	Refills:
	☐ Alternate Dosing:						_ QTY:	Refills:

Physician's Signature:	☐ DAW (Dispense as Written)	Date:			
Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.					



Date Shipment Needed: Click or tap to entera date.	_Ship To: □Patient □Prescriber
☐ Nursing needed; ☐ Training needed ► All the supplies including syringes a	nd needles will be dispensed if needed.

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## MULTIPLE SCLEROSIS INJECTABLE AGENTS REFERRAL FORM

PATIENT INFORMATION				
Patient Name:	DOB:			
INSURANCE INFORMATION				
☐ Please attach front and back of patient's insura	nce card (medical and prescription)			
COPAY CARD ENROLLMENT				
☐ Please check if enrolling in copay card	Copay ID:			
PRESCRIPTION INFORMATION				
□ Rebif® 22 mcg/0.5 mL Prefilled Syringe □ Rebiject™ Auto Injection □ Rebidose™ Auto Injection □ Dose Titration (syringes only) Week 1 & 2: 4.4 mcg (0.1 mL) SQ TIW (48 hours apart), Week 3 & 4: 11 mcg (0.25 mL SQ TIW (48 hours apart)			□ Enroll in MS Lifelines™  QTY: <u>28 day</u> Refills: <u>0</u>	
☐ Maintenance Dose: Week 5+: 22 mcg (0.5 mL) SQ ☐ ☐ Alternate Dosing:	TIW (48 hours apart)		ΓΥ: <u>28 day</u> ΓΥ:	Refills:
<ul> <li>□ Rebif® 44 mcg/0.5 mL Prefilled Syringe</li> <li>□ Dose titration: Week 1 &amp; 2: 8.8 mcg (0.2 mL) SQ TIW</li> <li>□ Maintenance Dose: Week 5+: 44 mcg (0.5 mL) SQ T</li> <li>□ Alternate Dosing:</li> </ul>	/ (48 hours apart), Week 3 & 4: 22 mcg (0.5 mL SQ T (48 hours apart)	Q1 Q1	Enroll in MS L TY: <u>28 day</u> TY: <u>28 day</u> TY:	Refills: 0 Refills: Refills:
☐ <b>Tysabri® 300 mg/15 mL</b> *Please fax Touch Enrollment to Patient must be enrolled in TOUCH. Call Biogen with questi	orm directly to TOUCH at 800.840.1278. Infused at Infusion Centers registered in TOL ons 1.800.456.2255	JCH program.		
□ Other:		Q1	TY:	Refills: