PALMETTO PHARM
USE AS WRITTEN

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

Date Shipment Needed: _____ Ship To: ☐Patient ☐Prescriber

☐ Nursing needed; ☐Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

# MULTIPLE SCLEROSIS ORAL AND TOPICAL AGENTS REFERRAL FORM

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | DOB: | Sex: ☐M ☐F | Weight: | ☐lbs. ☐kg. |
| SSN: | Phone: | Allergies: | | | |
| Address: | | City: | State: | Zip: | |
| Emergency Contact: | Phone: | | ☐ **Please attach demographic information** | | |

## PRESCRIBER INFORMATION

| | | | |
|---|---|---|---|
| Prescriber: | NPI: | DEA: | State Lic: |
| Supervising Physician: | Practice Name: | | |
| Address: | City: | State: | Zip: |
| Phone: Fax: | Key Office Contact: | Phone: | |

## DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

☐ Multiple Sclerosis ICD-10: G35 Type: ☐ Relapsing remitting ☐ Primary progressive ☐ Secondary progressive ☐ Progressive relapsing ☐ Other: _____

- Has patient been treated previously for this condition? ☐Yes ☐No Previous medication(s): _____
- Is patient currently on therapy? ☐Yes ☐No Current therapy: ☐Aubagio ☐Avonex ☐Bafiertam ☐Betaseron ☐Copaxone ☐Dimethyl Fumarate ☐Extavia ☐Gilenya ☐Glatiramer Acetate ☐Glatopa ☐Kesimpta ☐Lemtrada ☐Mavenclad ☐Mayzent ☐Novantrone ☐Ocrevus ☐Plegridy ☐Ponvory ☐Rebif ☐Tecfidera ☐Tysabri ☐Vumerity ☐Zeposia
- Will patient stop taking the above medication(s) before starting the new medication? ☐Yes ☐No, if yes; How long should patient wait before starting the new medication? _____
- 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

| | | |
|---|---|---|
| ☐ **Aubagio® 7 mg tablet** ☐ **Aubagio® 14 mg tablet**<br>☐ PO Once daily ☐Alternate Dose: _____ | ☐**Enroll in MS One to One® Program**<br>QTY: 28 day supply | Refills: ____ |
| ☐ **Dalfampridine EXTENDED RELEASE 10 mg tablet**<br>☐ PO BID (12 hours apart) ☐ PO Once daily ☐ Alternate Dose: _____ | QTY: 30 day supply | Refills: ____ |
| ☐ **Dimethyl Fumarate** 120 mg capsules PO BID | QTY: 14 capsules | Refills: ____ |
| ☐ **Dimethyl Fumarate** 240 mg capsules PO BID | QTY: 60 capsules | Refills: ____ |
| ☐ **Tecfidera® 30-day Starter Pack (120/240 mg)** Note: Will dispense for the first month only (no refill)<br>Take 120 mg PO BID for 7 days, then 240 mg PO BID for 23 days | ☐**Enroll in MS™**<br>QTY: 30 day supply | |
| ☐ **Tecfidera®** Maintenance Dose: Tecfidera (240 mg): Take 240 mg PO BID | QTY: 30 day supply | Refills: ____ |
| ☐ **Tecfidera®** Dose Modification: Tecfidera (120 mg): Take 120 mg PO BID | QTY: 7 day supply | Refills: ____ |
| ☐ **Gilenya® 0.5 mg Capsule**<br>1 capsule orally once daily Alternate Dose: _____ | ☐**Enroll in Gilenya Go Program™**<br>QTY: 28 day supply | Refills: ____ |
| ☐ **Ponvory® Starter Kit** Use as directed for initial 14 day dosage titration | **QTY: 14 day supply** | **Refills: 0** |
| ☐ **Ponvory® 20 mg tablet** PO once daily (beginning on day 15) | **QTY: 30 tablets** | **Refills: ____** |
| ☐ **Vumerity® 231 mg capsules**<br>☐ Initial: 1 capsule (231mg) by mouth BID for 7 days, then increase to 2 capsules (462mg) by mouth BID thereafter | **QTY: 106** | **Refills: 0** |
| ☐ Maintenance: 2 capsules (462mg) by mouth BID | **QTY: 120** | **Refills: ____** |
| ☐ **Zeposia® Titration Starter Kit**<br>0.23mg po once daily on days 1-4, then 0.46mg po once daily on days 5-7, then start 0.92mg po once daily starting on day 8 | QTY: 37 capsules | Refills: 0 |
| ☐ **Zeposia® 7 Day Kit**<br>0.23mg po once daily on days 1-4, then 0.46mg po once daily on days 5-7 | QTY: 7 capsules | Refills: 0 |
| ☐ **Zeposia® .92 mg capsules 1 capsule (0.92mg) po once daily** | **QTY: 30 day supply** | **Refills: ____** |
| ☐ **Cortrophin Gel** 5mL vials containing 80 USP units/mL<br>**Directions:** _____ | ☐ **Enroll in Cortrophin in your Corner™**<br>QTY: _____ | Refills: ____ |
| ☐ **Other**: _____ | QTY: _____ | Refills: ____ |

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

**Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. 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.**