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 INJECTABLE 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

☐ Avonex® 30 mcg — ☐ **Enroll in Above MS**

☐ Titration kit: ¼ dose IM week 1, ½ dose IM week 2, ¾ dose IM week 3, full dose IM week 4 — QTY: 28 day Refills: 0

☐ Pen ☐ Prefilled syringe ☐ Maintenance directions: 30mg IM once weekly — QTY: 28 day Refills: ____

☐ Alternate dosing _____ — QTY: ____ Refills: ____

☐ Betaseron® ☐ Betaject Lite® ☐ BetaConnect® Auto Injection — ☐ **Enroll in Beta PlusSM MS**

☐ 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: 0.875 mg (0.75 mL) SQ every other day, Week 7+: 0.25 mg (1 mL) SQ every other day — QTY: 28 day Refills: 1

☐ Maintenance Dose: 0.25 mg (1 ml) SQ every other day — QTY: 28 day Refills: ____

☐ Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ 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®**

☐ 20mg SQ once daily — QTY: 30 day Refills: ____

☐ 40mg SQ three times a week — QTY: 28 day Refills: ____

☐ Extavia® — ☐ **Enroll in Extavia Go**

☐ 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 — QTY: 28 day Refills: 1

☐ Maintenance Dose: 0.25 mg (1 mL) SQ every other day — QTY: 30 day Refills: ____

Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ Glatopa® 20mg/mL PFS ☐ Glatopa ® 40 mg/mL PFS — ☐ **Enroll in GlatopaCare™**

☐ 20 mg SQ every day — QTY: 30 day Refills: ____

☐ 40 mg/mL SQ 3 times per week — QTY: 28 day Refills: ____

☐ Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ **Kesimpta®** 20mg/0.4mL single-dose ☐ SensoReady Pen ☐ Prefilled Syringe

☐ Starter: 20mg SQ once weekly at weeks 0, 1, and 2 — QTY: 3 Refills: 0

☐ 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 enrollment 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 — 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: ____

☐ 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.

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

MULTIPLE SCLEROSIS INJECTABLE AGENTS REFERRAL FORM

PATIENT INFORMATION	
Patient Name:	DOB:
INSURANCE INFORMATION	
☐ **Please attach front and back of patient's insurance 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** ☐ **Enroll in MS Lifelines™**
- ☐ 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) — QTY: 28 day Refills: 0
- ☐ Maintenance Dose: Week 5+: 22 mcg (0.5 mL) SQ TIW (48 hours apart) — QTY: 28 day Refills: ____
- ☐ Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ **Rebif® 44 mcg/0.5 mL Prefilled Syringe** ☐ **Rebiject™ Auto Injection** ☐ **Rebidose™ Auto Injection** ☐ **Enroll in MS Lifelines™**
- ☐ Dose titration: Week 1 & 2: 8.8 mcg (0.2 mL) SQ TIW (48 hours apart), Week 3 & 4: 22 mcg (0.5 mL SQ T (48 hours apart) — QTY: 28 day Refills: 0
- ☐ Maintenance Dose: Week 5+: 44 mcg (0.5 mL) SQ TIW (48 hours apart) — QTY: 28 day Refills: ____
- ☐ Alternate Dosing: _____ — QTY: ____ Refills: ____

☐ **Tysabri® 300 mg/15 mL** *Please fax Touch Enrollment form directly to TOUCH at 800.840.1278. Infused at Infusion Centers registered in TOUCH program. Patient must be enrolled in TOUCH. Call Biogen with questions 1.800.456.2255

☐ **Other**: _____ 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.