ADVANCED PHARMACY & RESPIRATORY CARE SOLUTIONS

Today's Date _____

Date Needed _____

MULTIPLE SCLEROSIS REFERRAL FORM

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900 | Toll Free 800-464-7736 | Fax 949-348-7920
NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code: ☐ G35 Multiple Sclerosis OR ☐ Other Diagnosis _____
Type: ☐ Relapsing-remitting ☐ Primary progressive ☐ Secondary progressive ☐ Progressing Relapsing ☐ Other Diagnosis _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AVONEX®** PreFilled Syringe ☐ **AVONEX®** vial
SIG: Inject 30mcg IM once weekly ☐ Enroll in MS ActiveSource
Other_____ QTY: 28 Day Supply Refill _____

☐ **BETASERON®** ☐ **BETAJECT® LITE** ☐ Enroll in Beta Plus MS
☐ 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 (1ml) SQ every other day
Other_____ QTY: 30 Day Supply Refill _____

☐ **EXTAVIA®** ☐ Dose Titration ☐ Enroll in Extavia® Program
☐ 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 (1ml) SQ every other day
Other_____ QTY: 30 Day Supply Refill _____

☐ **COPAXONE®** ☐ **COPAXONE® AUTOJECT**
☐ 20 mg. SQ every day ☐ Enroll in Shared Solutions
Other_____ QTY: 30 Day Supply Refill _____

☐ **AMPYRA®** 10 mg Extended Release Tablets
Other_____ QTY: 30 Day Supply Refill _____

☐ **REBIF®** 22 mcg/0.5ml ☐ **REBIJECT®** Auto Injection
☐ Dose Titration ☐ Enroll in MS Lifelines
☐ 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)
☐ Maintenance Dose: Week 5+: 22 mcg (0.5 ml) SQ TIW (48 hrs apart)
Other_____ QTY: 28 Day Supply Refill _____
(No refills on starting does unless it is specified by Physician)

☐ **REBIF®** 44 mcg/0.5ml ☐ **REBIJECT®** Auto Injection
☐ Dose Titration (Rebif Titration Pack) Note: Will dispense Rebif Titration Pack for Dose Titration only for the first month (No Refill)
☐ Week 1 & 2: 8.8 mcg (0.2 ml) SQ TIW (48 hours apart)
☐ Week 3 & 4: 22 mcg (0,5 ml) SQ TIW (48 hours apart)
☐ Maintenance Dose: ☐ **REBIF®** 44 mcg/0.5ml
Week 5+: 44 mcg (0.5 ml) SQ TIW (48 hours apart)
Other_____ QTY: 28 Day Supply Refill _____
(No refill for Rebif® Titration Pack) ☐ Enroll in MS Lifelines

☐ **GILENYA™** 0.5mg Capsule ☐ 1 capsule orally once daily
Other_____ QTY: 28 Day Supply Refill _____

☐ **TYSABRI®** 300 mg/15 ml (Patient must be enrolled in TOUCH program)
☐ Dosage: 300 mg (in 100 ml NS) IV infusion over 1 hr every 4 wks
Other_____ QTY: 1 vial Refill _____

☐ **OCREVUS™** 300 mg/10 mL Single-dose Vial
☐ Starting dose: 300 mg IV infusion, followed two weeks later by a second 300 mg IV infusion
☐ Maintenance dose: 600 mg IV infusion every 6 months
QTY: _____ vial(s) Refill _____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.