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 MEDRXINFUSION.COM

Date Medication Needed: _____

Ship to: Patient Prescriber Other: _____

Self injection teaching needed Prescriber's office will teach

Multiple Sclerosis Referral Form
 (Subcutaneous/IM injections)

This referral form is provided in order to best serve our patients and prescribers. Patients may choose any pharmacy of their choice.

Complete patient demographics below or otherwise provide the information requested along with this referral form. Also needed: 1) Patient insurance information (front and back of card) 2) History and physical, chart notes, laboratory results and other diagnostic tests needed to support the use of this medication 3) patient's medication history related to their current diagnosis/problem.

Patient name: _____ Date of birth: _____ height: _____ weight: _____

Address: _____ Allergies/Intolerances: _____

Phone number(s): _____ No known allergies: _____

Treatment Diagnosis/Problem(s): _____ Failed Medication with reasons: _____

Prescriber name: _____ Contact person: _____

Office Address: _____

Phone number: _____ Fax number: _____ NPI number: _____

Prescription information

Avonex (interferon beta-1a) autoject pfs 30 mcg intramuscularly once weekly 4 week supply for _____ months

Avostartgrip (for pfs) titration kit for induction doses 7.5 mcg week 1, 15 mcg week 2, 22.5 mcg week 3

Betaseron/Extavia (interferon beta-1b) 0.3 mg pfs 0.25 mg subQ every other day 28/30 day supply for _____ months

Betaseron/Extavia induction schedule (0.0625 mg to 0.25 mg subQ every other day) _____
 28/30 day supply x 1 month

Copaxone (glatiramer) 20 mg pfs 20 mg subcutaneously every day 30 day supply for _____ months

Copaxone (glatiramer) 40 mg pfs 40 mg subQ 3 times weekly (at least every 48 hrs) 4 week supply for _____ months

Plegridy (peginterferon beta-1a) pen pfs 125 mcg subQ every 14 days 4 week supply for _____ months

Plegridy (peginterferon beta-1a) Induction pack pen pfs 63 mcg subQ day 1, 94 mcg subQ day 15 4 week supply

Rebif (interferon beta-1a) pfs, Rebidose autojector 22 mcg 44 mcg subQ 3 times weekly (at least every 48 hrs)
 4 week supply for _____ months

Rebif titration pack: Indicate induction schedule _____ 4 weeks supply x1 month

Dispense the necessary supplies to administer and hazardous waste disposal.

Physicians Signature: _____ Date: _____

IMPORTANT NOTICE: This form may contain confidential and privileged information and is only intended only for the person named herein. If you are not the named addressee, do not disseminate, distribute or copy this form or any of its contents. Please notify the sender immediately if you have received this document by mistake, then destroy this form.