# MULTIPLE SCLEROSIS REFERRAL FORM

Date: _____

**SUPERIOR BIOLOGICS**
**Fax Referral To: 914-747-1170**
**Phone: 855-747-1150**

SUPERIOR BIOLOGICS

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

## PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

## INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN:_____ Group: _____

## DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

**Primary Diagnosis**: _____ **Laboratory Results**: LEVF _____ **Date**: _____ **Platelets**: _____ **Date**: _____

**ANC**: _____ **Date**: _____ **Bilirubin**: _____mg/dL **Date**: _____ **Allergies:** _____

**Pregnancy Test**: _____(+/-) **Date**: _____ **Concurrent Meds**: _____

**Expected Date of First/Next Injection**: _____ **Date of Last Injection (if applicable):** _____

### Aubagio (teriflunomide)

☐ **7 mg** ☐ **14 mg**
**SIG**: ☐ Take one 7mg tablet orally once daily
☐ Take one 14mg tablet orally once daily
**QTY**: ☐ 28-day supply (1 box)
☐ 84-day supply (3 boxes)
Refills: _____

### Copaxone (glatiramer acetate)

☐ **20 mg PFS** ☐ **40 mg PFS**
**SIG**: ☐ Inject 20mg subcutaneously daily
☐ Inject 40mg subcutaneously three times per week
☐ Autoject 2
**QTY**: 20mg: ☐ 30-day supply ☐ 90-day supply
40mg: ☐ 28-day supply ☐ 84-day supply
Refills: _____

### Mitoxantrone HCL

☐ **20mg MDV** ☐ **25mg MDV** ☐ **30mg MDV**
**SIG**: ☐ Dilute and administer 12mg/m² as IV infusion every 3 months
**QTY**: _____ Refills: _____

### Glatiramer acetate

☐ **20 mg PFS**
**SIG**: ☐ Inject 20 mg subcutaneously daily
**QTY**: ☐ 30-day supply ☐ 90-day supply
Refills: _____

### Avonex (interferon beta-1a)

☐ **30 mcg PFS** ☐ **30 mcg single dose vl.**
☐ **30 mcg Avonex Pen (single dose)**
**SIG**: ☐ Inject 30mcg intramuscularly once weekly
☐ Dose Titration: Week 1 – inject 7.5mcg IM; Week 2 – inject 15mcg IM; Week 3 – inject 22.5mcg IM; Week 4+ - inject 30mcg IM
**QTY**: ☐ 4-week supply (1 kit)
☐ 12-week supply (3 kits)
Refills: _____

### Extavia (interferon beta-1b)

☐ **0.3 mg vial**
**SIG**: ☐ Inject 0.25mg/1mL subcutaneously every other day
☐ Dose Titration: Weeks 1-2 – inject 0.0625mg/0.25mL; Weeks 3-4 – inject 0.125mg/0.50mL; Weeks 5-6 – inject 0.1875mg/0.75mL; Weeks 7+ -- inject 0.25mg/1mL
**QTY**: ☐ 30-day supply (1 kit)
☐ 90-day supply (3 kits)
Refills: _____

### Tysabri

Tysabri is available through the Biogen TOUCH Prescribing Program. Please call (800) 456-2255.

### Betaseron

☐ **0.3 mg vial**
**SIG**: ☐ Inject 0.25mg (1 mL) sub-c every other day
☐ Dose Titration: Weeks 1-2 – inject 0.0625mg/0.25mL; Weeks 3-4 – inject 0.125mg/0.50mL; Weeks 5-6 – inject 0.1875mg/0.75mL; Weeks 7+ -- inject 0.25mg/1mL
**QTY**: ☐ 28-day supply (1 kit/14 vials)
☐ 84-day supply (3 kits/42 vials)
Refills: _____

### Rebif (interferon beta-1a)

☐ **0.3 mg vial**
**SIG**: ☐ Inject 0.25mg (1 mL) sub-c every other day
☐ Dose Titration: Weeks 1-2 – inject 0.0625mg/0.25mL; Weeks 3-4 – inject 0.125mg/0.50mL; Weeks 5-6 – inject 0.1875mg/0.75mL; Weeks 7+ -- inject 0.25mg/1mL
**QTY**: ☐ 28-day supply (1 kit/14 vials)
☐ 84-day supply (3 kits/42 vials)
Refills: _____

**Other/Notes**:_____
_____
_____
_____
_____
_____

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