UnityPoint at Home

SPECIALTY PHARMACY
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

MULTIPLE SCLEROSIS REFERRAL

PATIENT INFORMATION

Please send a copy of ALL of patient's Prescription, Primary and Secondary insurance cards (both sides). Also include any other beneficial information for prior authorization and dispensing assessments.

Patient Name _____ **DOB** _____ **Gender** ☐ Male ☐ Female

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work phone** _____ **Email** _____

Primary Language ☐ English ☐ Spanish ☐ Other specify_____ **Allergies** _____

RX Member ID _____ **RX Group ID** _____ **RX PCN** _____ **RX BIN** _____

PRESCRIPTION INFORMATION

☐ **Aubagio®** (Teriflunomide) Tablet — Disp. 28 day supply Refill: x_____

Sig: ☐ Take 7 mg PO once daily
☐ Take 14 mg PO once daily

☐ **Avonex®** (Interferon Beta-1a) ☐ 30 mcg/0.5 mL Pen ☐ 30 mcg/0.5 mL Pre-Filled Syringe ☐ 30 mcg Vial
Disp. 28 day supply Refill: x_____

Sig: ☐ Inject 30 mcg (6 million IU) IM once weekly
☐ Inject 7.5 mcg IM once (week 1) then increase dose by 7.5 mcg weekly until recommended dose of 30 mcg/week
☐ Other: _____

☐ **BETASERON®** (Interferon Beta-1b) 0.3 mg Lyophilized Powder- Single Use Vial — Disp. 28 day supply Refill: x_____

Sig: ☐ Inject 0.0625 mg SC every other day, and increase by 0.0625 mg SC every 2 weeks to a dose of 0.25 mg every other day
☐ Inject 0.25 mg SC every other day

☐ **Copaxone®** (Glatiramer) Pre-Filled Syringe — Disp. One month supply Refill: x_____

Sig: ☐ Inject 20 mg SC once daily *Note some payors may require substitution to Glatopa
☐ Inject 40 mg SC three times weekly

☐ **Extavia®** (Interferon Beta-1b) 0.3 mg Lyophilized Powder- Single Use Vial — Disp. 30 day supply Refill: x_____

Sig: ☐ Inject 0.0625 mg SC every other day, and increase by 0.0625 mg SC every 2 weeks to a dose of 0.25 mg every other day
☐ Inject 0.25 mg SC every other day

☐ **Gilenya®** (Fingolimod) Capsule — Disp. 30 day supply Refill: x_____

Sig: ☐ Take 0.5 mg PO once daily

☐ **Glatopa®** (Glatiramer) Pre-Filled Syringe — Disp. 30 day supply Refill: x_____

Sig: ☐ Inject 20 mg SC once daily

☐ **Rebif®** (Interferon Beta-1a) ☐ 22 mcg Pre-Filled Syringe ☐ 44 mcg Pre-Filled Syringe ☐ Rebif Starter Pack
☐ Rebidose 22 mcg Autoinjector ☐ Rebidose 44 mcg Autoinjector ☐ Rebidose Autoinjector Starter Pack
Disp. 28 day supply Refill: x_____

Sig: ☐ Inject 22 mcg SC three times weekly
☐ Inject 44 mcg SC three times weekly
☐ Other: _____

☐ **OTHER** _____

Date:		**Signature:** (No Stamps)	

Prescriber authorization: By signing I certify that the above therapy is medically necessary. I authorize this pharmacy to act as my authorized agent to secure coverage and initiate the insurance prior authorization for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials regarding coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

PRESCRIBER INFORMATION

Print Prescriber's Name: _____ NPI: _____ Phone _____

Address _____ City _____ State _____ Fax _____

CLINICAL INFORMATION

☐ G35 MULTIPLE SCLEROSIS ☐ Other ICD 10 Code(s): _____

Other: _____

Height: _____ Weight: _____ SCR: _____ Collection Date: _____

TB Skin Test Result _____ TB Skin Test Result Date: _____

Previous therapy (include dates): _____