This referral form is provided to help with patient safety. Prescribers are reminded patients may choose any pharmacy of their choice.

Avella Specialty Pharmacy

Multiple Sclerosis Prescription Referral Form

Distribution Locations

○ **Florida**
Avella of Orlando
Ph. 407.942.0080
Fax 407.942.0085

○ **Natl. Distribution Ctr.**
Avella of Deer Valley
Ph. 877.546.5779
Fax 877.546.5780

avella.com
If you need a medication not listed, please contact us.

Date Medication Needed: ___ ___ _____ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up (store location): _____ Injection training by pharmacy? ☐

1: Patient Information

Patient Name: _____ **Birthdate:** ___ ___ _____ **Sex:** ○ Male ○ Female **Height:** _____ **Weight:** _____ ○ lbs. ○ kg.

Soc. Sec. #: _____ **Preferred Phone:** ( ) _____ - _____ **Known Allergies:** _____

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

Alternate Caregiver Name: _____ **Preferred Phone:** ( ) _____ - _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

☐ _____ ☐ _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** (_____) _____ - _____ **Fax:** (_____) _____ - _____

City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone:** (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: 340 Multiple Sclerosis ☐ **Other:** _____

Has the patient been previously treated for this condition? ○ Yes ○ No

Prior failed medication (medication and duration of treatment/reason for d/c):

☐ _____

Patient currently on therapy? ○ Yes ○ No Medication(s): _____

Will patient be stoping above medication before starting new therapy?

○ Yes ○ No Discontinuation Date: _____

Is prescriber a Neurologist? If no, please include neurology consult if available.

Diagnosis: ☐ **Other:** _____

Number of relapses in past year: _____

Last MRI date: _____ **Any MRI changes?** ○ Yes ○ No

Inection training completed by:

Novantrone:

Is patient's LVEF <50%? ○ Yes ○ No

What is lifetime (cumulative) Novantrone dose (mg/m2)? _____

Copy of last CBC with differential: _____

Is patient pregnant, nursing or planning pregnancy? ○ Yes ○ No ○ N/A

☐ **Serum Creatine** _____ ☐ **Creatinine Clearance** _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Avonex®**	☐ 30mcg Prefilled Syringe #4 ☐ 30mcg Pen #4	☐ Inject 30mcg IM once weekly	4 week supply	
☐ **Betaseron®**	☐ 0.3mg vial	☐ **Dose Titration:** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ **Maintenance Dose:** 0.25mg /1ml subcutaneously QOD ☐ **Other:**	4 week supply	
☐ **Copaxone®**	☐ 20mg Prefiled Syringe	☐ 20mg SQ QD	4 week supply	
☐ **Extavia®**	☐ 0.3mg vial	☐ **Maintenance Dose:** 0.25mg /1ml subcutaneously QOD ☐ **Dose Titration:** • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ **Other:**	4 week supply	
☐ **Gilenya®**	☐ 0.5mg capsule	☐ Take 0.5mg po QD	4 week supply	
☐ **Rebif®**	☐ Titration Pack (8.8mcg/22mcg) ☐ 22mcg Prefilled Syringe ☐ 44mcg Prefilled Syringe	☐ Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) ☐ **Maintenance:** Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Maintenance:** Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) ☐ **Other:**	4 week supply	

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____

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