US Bioservices
AmerisourceBergen

Multiple Sclerosis Referral Form

Phone: (866) 916-0578
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:________

1. Patient Information

Last Name: ________ Home Phone: ________ Work/Mobile Phone: ________
First Name: ________ Home Address: ________
S.S. #: ________ Date of Birth: ________ City: ________ State: ________ Zip: ________
Guardian/Caregiver: ________ Sex: ☐ Male ☐ Female Height: ________ Weight: ________ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: ________ Phone: ________ Prescription Card: ________ Phone: ________
Subscriber Name: ________ Policy #: ________ BIN/PCN: ________
Policy #: ________ Group #: ________ Medicare #: ________ Medicaid #: ________

3. Prescriber Information

Prescriber Name: ________ ☐ MD ☐ DO ☐ NP ☐ PA License #: ________ NPI #: ________ DEA #: ________
Practice Name: ________ Phone: ________ Fax: ________
Address: ________ Office Contact: ________ Phone: ________
City: ________ State: ________ Zip: ________ Collaborating Physician: ________

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies: ________
Meds Tried & Failed: ________
Current Medications: ________
Does MRI show features consistent with a MS diagnosis? ☐ Yes ☐ No
Is this the first clinical episode of MS for this patient? ☐ Yes ☐ No
Is the patient's functional status ambulatory? ☐ Yes ☐ No

☐ Multiple Sclerosis (ICD-10 Code: G35)
☐ Relapsing Remitting (RRMS) ☐ Progressive Relapsing (PRMS)
☐ Primary Progressive (PMS) ☐ Secondary Progressive (SPMS)
☐ Other ICD-10 Diagnosis Code: ________
Other Disease States: ________

5. Prescription Information

Medication	DISPENSE	REFILLS
AMPRYA® ☐ 10mg Tablets • Take 10mg PO twice daily		
AVONEX® ☐ 30mcg LYO ☐ 30mcg PFS ☐ 30mcg PFS Autoinjector		
☐ Titration Dosing • Week 1: Inject 7.5mcg IM QW • Week 3: Inject 22.5mcg IM QW • Week 2: Inject 15mcg IM QW • Week 4: Inject 30mcg IM QW		
☐ Maintenance Dosing: Inject 30mcg/0.5mL IM Q7 days		
BETASERON®		
☐ Titration Dosing • Weeks 1-2: Inject 0.0625mg SC QOD • Weeks 5-6: Inject 0.1875mg SC QOD • Weeks 3-4: Inject 0.125mg SC QOD • Weeks 7+: Inject 0.25mg SC QOD	1 Box	1
☐ Maintenance Dosing: Inject 1mL (0.25mg) SC QOD	1 Box	
COPAXONE® ☐ 20mg/PFS ☐ 40mg/PFS ☐ Inject 20mg/mL SC QD ☐ Inject 40mg/mL SC 3XW, at least 48 hours apart		
EXTAVIA®		
☐ Titration Dosing • Weeks 1-2: Inject 0.0625mg SC QOD • Weeks 5-6: Inject 0.1875mg SC QOD • Weeks 3-4: Inject 0.125mg SC QOD • Weeks 7+: Inject 0.25mg SC QOD	1 Box	1
☐ Maintenance Dosing: Inject 1mL (0.25mg) SC QOD	1 Box	
GLATOPA® ☐ 20mg PFS • Inject 20mg SC QD		

Medication	DISPENSE	REFILLS
GILENYA® ☐ 0.5mg Caps • Take 0.5mg PO QD with or without food		
OCREVUS™ ☐ 300mg/10mL SDV ☐ Start Dose: Infuse 300mg IV, followed two weeks later by a second 300mg infusion. ☐ Maintenance Dose: Infuse 600mg IV Q6M	2 Vials	
PLEGRIDY® Titration Pack ☐ Starter PFS ☐ Starter PEN • Inject 63mcg SC on day 1, followed by 94mcg on day 2, followed by 125mcg on day 29		
PLEGRIDY® ☐ 125mcg/0.5mL Pen ☐ 125mcg/0.5mL PFS • Inject 125mcg SC Q14D		
REBIF® Titration Pack ☐ PFS ☐ Rebidose Autoinjector		
☐ 22mcg Dosing (PFS Only) • Weeks 1-2: Inject 4.4mcg SC TIW • Weeks 3-4: Inject 11mcg SC TIW	1 Pack	
☐ 44mcg Dosing • Weeks 1-2: Inject 8.8mcg SC TIW • Weeks 3-4: Inject 22mcg SC TIW	1 Pack	
REBIF® ☐ 22mcg Autoinjector ☐ 22mcg PFS ☐ 44mcg Autoinjector ☐ 44mcg PFS ☐ Inject 22mcg SC TIW ☐ Inject 44mcg SC TIW	1 Box	
TECFIDERA® ☐ 30 Day Starter Pack: 120mg PO BID x7 days + 240mg PO BID x 23 days ☐ **120mg Capusles:** Take 120mg PO BID x 7 days ☐ **240mg Capusles:** Take 240mg PO BID x 30 days		

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

Patient Signature ________ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

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