MULTIPLE SCLEROSIS PRESCRIPTION REFERRAL FORM

151 Cochituate Rd | Framingham, MA 01701
PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name ______ D.O.B ______ Weight ______ ☐ Male ☐ Female
Address ______ City ______ State ______ Zip ______
Daytime Telephone ______ Evening Telephone ______ Cell ______ Email ______
Ship to patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed ______
ICD-10 Diagnosis ☐ G35 Multiple Sclerosis **OR** Other ______ Allergies ______
Patient currently on therapy ☐ Yes ☐ No Date of next blood work ______ Comments ______

Insured's Name ______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare # ______
Prescription Card ☐ Yes ☐ No If yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______
BIN# ______ PCN# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License # ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

AVONEX ADMINISTRATION PACK 30 mcg Pre-Filled
SIG ☐ Inject 30 mcg IM once weekly
☐ Other ______
QTY: # ______ Weeks (1 pack = 4 week supply) Refills X ______

BETASERON 0.3 mg Vials
SIG ☐ Inject ______ SC every other day
☐ Other ______
QTY: # ______ Weeks (1 pack = 4 week supply) Refills X ______

COPAXONE
☐ **40 mg/mL Syringe**
SIG ☐ Inject 40 mg SC three times weekly
☐ Other ______
☐ **20 mg/mL Syringe**
SIG ☐ Inject 20 mg SC once daily
☐ Other ______
QTY: # ______ Syringes Refills X ______

EXTAVIA VIALS
SIG ☐ Inject ______ SC every other day
Other ______
QTY: # ______ Weeks (1 box = 4 week supply) Refills X ______

GILENYA
0.5 mg ______ Orally once daily QTY: 28 Refill X ______

REBIFF TITRATION PACK 12 Syringes
SIG ☐ 8.8 mcg SQ TIW - weeks 1 & 2 ☐ 22 mcg SQ TIW - weeks 3 & 4
Maintenance Dose following week 3 & 4
QTY: # ______ Boxes (1 box = 4 week supply) Refills X ______

REBIF 22mcg/0.5 mL SIG 22 mg (0.5mL) SQ TIW (48 hrs apart)
QTY # ______ Boxes (1 box = 4 week supply) Refills X ______

REBIF 44mcg/0.5 mL (Maintenance) SIG starting wk 5: 44 mcg (0.5mL) SQ TIW (48hrs apart)
QTY # ______ Boxes (1 box = 4 week supply) Refills X ______

OTHER ______ SIG ______
QTY: ______ Refills X ______

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) ______ **Date** ______

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