LIFECARE PHARMACY

www.lifecarepharmacy.com

Neurology & Multiple Sclerosis Referral Form

Surescripts ID #:

Office #: 1-210-881-0890
Fax #: 1-210-569-6464

Referral Info

PATIENT INFORMATION

PATIENT NAME		SSN #:	DOB:
ADDRESS:		CITY:	STATE: ZIP:
HOME PHONE:	CELL PHONE:	HEIGHT: WEIGHT:	GENDER: MALE FEMALE
Email ADDRESS:		DIAGNOSIS CODE:	

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

PRIOR TREATMENT HISTORY

o Avonex® o Betaseron® o Copaxone® o Glatopa™ o Extavia® o Gilenya® o Rebif® o Other_____

NEUROLOGY MEDICATIONS

Tetrabenazine o 12.5mg o 25mg
Sig/Directions:

MS MEDICATIONS

Avonex® - o Enroll in Above MS
o 30 mcg (o Prefilled Syringe o Pen o Vial) inject IM once weekly

Betaseron® - o Enroll in BETAPLUS®
o Starting Titration:62.5mcg SubQ Every Other Day Weeks 1-2
o Maintenance Dosing:250mcg (1mL) SubQ Every Other Day
o BetaConnect

Copaxone® - o Enroll in Shared Solutions® (Glatiramer Acetate)
o 20mg SubQ Every Day o 40mg SubQ Three Times Per Week

If want brand, please write "Brand Medication Necessary

Glatopa™ - o Enroll in GlatopaCare™
o 20mg SubQ Every Day

Extavia® - o Extavia Go Program®
o Starting Titration: 62.5mcg SubQ Every Other Day Weeks 1-2
o Maintenance Dosing: 250mcg (1mL) SubQ Every Other Day

Gilenya® - o Enroll in Gilenya GoProgram
o 0.5mg by Mouth Once a Day

Rebif® - o Enroll in MS LifeLines®
o Prefilled Syringe/Rebiject II® o Rebif Rebidose®

Titration Pack:
o Goal Dose 22 mcg: (Full Dose Therapy Beginning Week 5) 4.4 mcg/0.1 mL SubQ Three Times Weekly Week 1-211mcg/0.25mL SubQ Three Times Weekly Weeks 3-4

o Goal Dose 44 mcg: (Full Dose Therapy Beginning Week 5) 8.8 mcg/0.1 mL SubQ Three Times Weekly Week 1-222mcg/0.25mL Three Times Weekly Weeks 3-4

Maintenance Dosing:
o 44mcg o 22mcg SubQ Three Times Per Week
o **Rebiject*** (*Will come from MS Lifelines®)

○ **OTHERS**

Strength:

Sig/Directions:

Quantity: **Refills:**

PHYSICIAN INFORMATION

Prescriber Name:	**Phone:**	**Fax:**
Office Contact/Faxed by:	**Email:**	
NPI#:	**TAXID#:**	**Ship To:** O **Patient** O **MD 1ST Fill Only** O **MD All Orders**
Prescriber Signature:		
○ **Dispense as written**	**Date**	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

* We will let you know within 2 hours if your patient can be admitted pending insurance Qualification or non-admitted and triaged to another pharmacy

This prescription is valid only if transmitted by Facsimile machine by a licensed prescriber

LIFECARE PHARMACY