CALIFORNIA SPECIALTY PHARMACY

Multiple Sclerosis Referral Form

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

Your CSP Contact: _____ and Tel: _____

PATIENT INFORMATION:

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____
Email: _____
Soc. Sec#: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ ft ☐ cm
Date of Birth: _____ Sex: ☐ Male ☐ Female BSA: _____

PHYSICIAN INFORMATION: Ship to: ☐Physician's Office ☐Patient's Home

Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Office Email: _____
Key Office Contact: _____
State LIC #: _____ NPI# _____ DEA# _____

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS (front + back)**

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

DIAGNOSTIC INFORMATION:

☐ Multiple Sclerosis ICD-9CM 340. ☐ Other Diagnosis: _____

- Has patient been treated previously for this condition? ☐ Yes ☐ No Medication(s) failed: _____
- Is patient currently on therapy? ☐ Yes ☐ No Type /medication(s): _____
- will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No
- If yes, How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: _____

MEDICATIONS & DIRECTIONS

Prescription	Directions	Quantity	Refill	
☐ **Avonex®** (interferon beta-1a)	☐ Week 1 Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; ☐ Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; ☐ Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; ☐ Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	☐ 4 x 30 mcg	☐ Pens ☐ PFS ☐ Vials	0
	☐ Inject 30 mcg intramuscularly once weekly	☐ 4 x 30 mcg	☐ Pens ☐ PFS ☐ Vials	
☐ **Betaseron®** (interferon beta-1b)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; ☐ Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	☐ 14 x 0.3 mg	Vials	0
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day: ☐ Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	☐ 14 x 0.3 mg	Vials	0
	☐ Inject 0.25 mg (1 mL) subcut every other day	☐ 14 x 0.3 mg	Vials	
☐ **Copaxone®** (glatiramer acetate)	☐ Inject 20 mg subcut once daily ☐ Inject 40 mg subcut three times per week at least 48 hours apart	☐ 30 x 20 mg ☐ 12 x 40 mg	PFS	
☐ **Glatiramer acetate**	☐ Inject 20 mg subcut once daily ☐ Inject 40 mg subcut three times per week at least 48 hours apart	☐ 30 x 20 mg ☐ 12 x 40 mg	PFS	
☐ **Glatopa®** (glatiramer acetate)	☐ Inject 20 mg subcut once daily ☐ Inject 40 mg subcut three times per week at least 48 hours apart	☐ 30 x 20 mg ☐ 12 x 40 mg	PFS	
☐ **Gilenya®** (fingolimod)	☐ Take 0.5 mg by mouth once daily	☐ 30 x 0.5 mg capsules		
☐ **Extavia®** (interferon beta-1b)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; ☐ Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	☐ 15 x 0.3 mg	Vials	0
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day: ☐ Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	☐ 15 x 0.3 mg	Vials	0
	☐ Inject 0.25 mg (1 mL) subcut every other day	☐ 15 x 0.3 mg	Vials	
☐ **IVIG - Intravenous Immunoglobulin**	☐ Home Infusion ☐ MD's Office Infusion ☐ Sig: _____	☐ 28 day supply		
☐ **Ocrevus®** (ocrelizumab)	☐ Loading: Infuse 300 mg intravenously on day 1 and day 15	☐ 2 x 30mg/10mL	Vials	0
	☐ Infuse 600 mg intravenously on day 180 then infuse 600 mg every 6 months	☐ 2 x 30mg/10mL	Vials	
☐ **Rebif ®** (interferon beta-1a)	☐ Titration for 22 mcg maintenance dose: Inject 4.4 mcg subcutaneously three times a week for Weeks 1 and 2, then inject 8.8 mcg subcutaneously three times a week for Weeks 3 and 4	☐ 28 day Titration Pack	☐ Autoinjector ☐ PFS	0
	☐ Inject 22 mcg subcutaneously three times a week	☐ 12 x 22 mcg	☐ Autoinjector ☐ PFS	
	☐ Titration for 44 mcg maintenance dose: Inject 8.8 mcg subcutaneously three times a week for Weeks 1 and 2, then inject 22 mcg subcutaneously three times a week for Weeks 3 and 4	☐ 28 day Titration Pack	☐ Autoinjector ☐ PFS	0
	☐ Inject 44 mcg subcutaneously three times a week	☐ 12 x 44 mcg	☐ Autoinjector ☐ PFS	
☐ **Tecfidera** (dimenthyl fumarate)	☐ Take 120 mg by mouth twice daily for 7 days, then 240 mg by mouth twice daily thereafter	☐ 30-day starter pack	Capsules	0
	☐ Take 240 mg by mouth twice daily ☐ _____	☐ 60 x 240 mg capsules ☐ _____	Capsules	
☐ **Vumerity** (diroximel fumarate)	☐ Take 231 mg by mouth twice daily for 7 days, then 462 mg by mouth twice daily thereafter	120 Capsules		
	☐ Take 462 mg by mouth twice daily	120 Capsules		

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

I authorize California Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
x		