

# NEUROLOGY P-Z

## Prescription Referral Form

Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7629 | 1501 Belle Isle Ave #150 Mt Pleasant SC 29464

### PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Patient Preferred Language:  English  Spanish  \_\_\_\_\_

### PRESCRIBER INFORMATION

Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Office's Preferred Method of Contact:  Phone  Fax  Portal  Email: \_\_\_\_\_  Other: \_\_\_\_\_

### PATIENT CLINICAL INFORMATION / HISTORY -PLEASE FORWARD ALL CHART NOTES AND LABWORK

Diagnosis: Multiple Sclerosis ICD 10:  G35  Other: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Tb Test Results: \_\_\_\_\_  
 Relapsing Remitting  Primary Progressive  Secondary Progressive  Progressive Relapsing  
 Drug Allergies: \_\_\_\_\_ Previous / Failed Medications: \_\_\_\_\_

### PRESCRIBING INFORMATION

NEW  RESTART  CONTINUING | SHIPPING PREFERENCE:  Deliver Medication to Patient  Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> PLEGRIDY	<input type="checkbox"/> Starter Pack (Pen) 63mcg/0.5mL/94mcg/0.5mL	<input type="checkbox"/> <u>Induction Dose:</u> Inject 63mcg SC on day 1, then inject 94mcg SC on day 15, then inject 125mcg SC on day 29		
	<input type="checkbox"/> Starter Pack (PFS) 63mcg/0.5mL/94mcg/0.5mL	<input type="checkbox"/> <u>Maintenance Dose:</u> Inject 125mcg SC every 14 days		
	<input type="checkbox"/> 125mcg/0.5mL PFS	<input type="checkbox"/> <u>Induction Dose:</u> Inject 63mcg IM on day 1, then inject 94mcg IM on day 15, then inject 125mcg IM on day 29		
	<input type="checkbox"/> 125mcg/0.5mL Pen	<input type="checkbox"/> <u>Maintenance Dose:</u> Inject 125mcg IM every 14 days		
<input type="checkbox"/> REBIF	<input type="checkbox"/> Titration Pack (PFS)	<input type="checkbox"/> <u>Induction Dose:</u> GOAL DOSE 22mcg Weeks 1-2: Inject 4.4mcg SC three times weekly Weeks 3-4: Inject 11mcg SC three times weekly Weeks 5+: Inject 22mcg SC three times weekly		
	<input type="checkbox"/> Titration Pack (Rebidose)	<input type="checkbox"/> <u>Maintenance Dose:</u> Inject 22mcg SC three times weekly		
	<input type="checkbox"/> 22mcg/0.5mL PFS	<input type="checkbox"/> <u>Induction Dose:</u> GOAL DOSE 44mcg Weeks 1-2: Inject 8.8mcg SC three times weekly Weeks 3-4: Inject 22mcg SC three times weekly Weeks 5+: Inject 44mcg SC three times weekly		
	<input type="checkbox"/> 44mcg/0.5mL PFS	<input type="checkbox"/> <u>Maintenance Dose:</u> Inject 44mcg SC three times weekly		
<input type="checkbox"/> DIMETHYL FUMARATE	<input type="checkbox"/> Starter Pack	<input type="checkbox"/> <u>Induction Dose:</u> Take 120mg by mouth twice daily for 7 days		
	<input type="checkbox"/> 120mg Capsules <input type="checkbox"/> 240mg Capsules	<input type="checkbox"/> <u>Maintenance Dose:</u> Take 240mg by mouth twice daily		
<input type="checkbox"/> TYSABRI	<input type="checkbox"/> 300mg/mL Vial	<input type="checkbox"/> Infuse 300mg via IV over one hour every 4 weeks		
<input type="checkbox"/> ZEPOSIA	<input type="checkbox"/> Titration Starter Kit	<input type="checkbox"/> <u>Titration:</u> Take 0.23mg by mouth days 1-4, then 0.46mg days 5-7, then 0.92mg thereafter	7	
	<input type="checkbox"/> 0.92mg Capsule	<input type="checkbox"/> <u>Maintenance Dose:</u> Take 0.92mg by mouth once daily		

### PRESCRIPTION SIGNATURE

Dispense as Written: \_\_\_\_\_ Substitution Permitted: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Blue Sky Specialty Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer