Multiple Sclerosis
Prescription Referral Form (A to G)

Sterling SPECIALTY PHARMACY

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Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Date Medication Needed:_____ **Ship to:** ❑ Patient's Home ❑ Prescriber's Office ❑ Pharmacy to Coordinate

§1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name:_____ Birthdate:_____ Sex: ❑ Male ❑ Female Height:_____ Weight:_____ ❑ lbs. ❑ kg.

Allergies:_____ Patient Primary Language: ❑ English ❑ Spanish ❑ Other:_____ ❑ Hearing Impaired

Patient Phone: _____ Secondary Phone:_____ Patient Email:_____ Caregiver Name:_____

Patient Address:_____ City:_____ State:_____ Zip:_____

§2 Provider/Prescriber Information

Clinic Name:_____ Provider Name:_____ DEA#:_____ NPI#:_____

Provider Address:_____ City:_____ State:_____ Zip:_____

Key Contact:_____ Phone:_____ Fax:_____ Email:_____

§3 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs & Tests with the prescription to expedite Prior Authorization.

Diagnosis/ICD-10:_____ Diagnosis Date:_____ Other:_____ ❑ Relapse/Remitting ❑ Progressive

If Relapse Remitting: Has the patient experienced a first clinical episode? ❑ Yes ❑ No ❑ Attach MRI Results Date:_____

Past failed therapies:_____

Does the patient have any contraindication(s) to therapy? ❑ Yes ❑ No If Yes:_____

Injection Training: ❑ Pharmacist to Provide ❑ Patient Trained in MD Office ❑ Manufacturer Nurse Support

If Prior Authorization is Denied: Sterling will inform provider of preferred formulary alternatives and/or draft an appeal letter as advisable.

§4 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Patient Name:_____ Patient Birthdate:_____

Medication	Dose/Strength	Direction	Qty.	Refills
❑ AMPYRA®	❑ 10mg Tablets	❑ Take one tablet by mouth twice daily with, or without, food **Note: medication request should be sent to Ampyra hub via ampyra-hcp.com using the Medication Request Form**	60	
❑ AUBAGIO®	❑ 7mg Tablets ❑ 14mg Tablets	❑ Take one tablet by mouth once daily with, or without, food	30	
❑ AVONEX®	❑ 30mcg Prefilled Syringe ❑ 30mcg Single Dose Vial ❑ 30mcg Avonex® Pen	❑ Inject 30mcg IM once a week ❑ **Tritration:** 7.5mcg weekly (over a 4 week period) until target dose of 30mcg is reached	1 Pack	
❑ BETASERON®	❑ 0.3mg Lyophilized Powder	❑ Inject 0.25mg (1ml) SC every other day ❑ **Tritration:** **Weeks 1-2:** Inject 0.0625mg (0.25ml) SC every other day **Weeks 3-4:** Inject 0.125mg (0.50ml) SC every other day **Weeks 5-6:** Inject 0.1875mg (.75ml) SC every other day **Weeks 7 and Onward:** Inject 0.25mg (1ml) SC every other day	1 Pack	
❑ COPAXONE®	❑ 20mg Prefilled Syringe ❑ 40mg Prefilled Syring	❑ Inject 20mg SC daily ❑ Inject 40mg SC three times per week ❑ Other: _____	1 Pack	
❑ EXTAVIA®	❑ 0.3mg Lyophilized Powder	❑ Inject 0.25mg (1ml) SC every other day ❑ **Tritration:** **Weeks 1-2:** Inject 0.0625mg (0.25ml) SC every other day **Weeks 3-4:** Inject 0.125mg (0.50ml) SC every other day **Weeks 5-6:** Inject 0.1875mg (.75ml) SC every other day **Weeks 7 and Onward:** Inject 0.25mg (1ml) SC every other day	1 Pack	
❑ GILENYA®	❑ 0.25mg Capsules ❑ 0.50mg Capsules	❑ **Patients 10 years of age or older and weighing > 40kg:** Take one 0.50mg capsule by mouth once daily with, or without, food ❑ **Patients 10 years of age or older and weighing ≤ 40kg:** Take one 0.25mg capsule by mouth once daily with, or without, food	30	
❑ GLATOPA™	❑ 20mg Prefilled Syringe	❑ Inject 20mg SC daily	30	
❑ _____	❑ _____	❑ _____		
❑ _____	❑ _____	❑ _____		

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Dispense as written:_____ Date:_____ Substitution Permissable:_____ Date:_____

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.

# of Prescriptions:_____