Multiple Sclerosis
Prescription Referral Form (H to Z)

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
❑ OCREVUS®	❑ 300mg/10ml Single Dose Vial	❑ **Induction:** Infuse 300mg via IV over 2.5 hours on day 1 and day 15. Start Maintenance dose six months after first 300mg dose.	1	1
		❑ **Maintenance:** Infuse 600mg via IV over 3.5 hours every six months	2	
❑ PLEGRIDY®	❑ Starter Pack: Plegridy® Pen Injector ❑ Starter Pack: Prefilled Syringe	❑ **Induction:** Inject 63mcg SC on day 1 and 94mcg on day 15, then start Maintenance dose on day 29	1	0
	❑ 125mcg Plegridy® Pen Injector ❑ 125mcg Prefilled Syringe	❑ **Maintenance:** Inject 125mcg SC every other week	2	
❑ REBIF®	❑ Rebidose® Tritration Pack *(contains six 8.8mcg pre-filled autoinjectors and six 22mcg pre-filled autoinjectors)*	❑ **Tritration Pack:** **Weeks 1-2:** Use one 8.8mcg autoinjector three times a week, at least 48 hours apart **Weeks 3-4:** Use one 22mcg autoinjector three times a week, at least 48 hours apart	1 Pack	0
	❑ 22mcg Rebif® Rebidose® Autoinjector ❑ 44mcg Rebif® Rebidose® Autoinjector ❑ 22mcg Prefilled Syringe ❑ 44mcg Prefilled Syringe	❑ **22mcg Directions:** **Weeks 1-2:** Inject 4.4mcg three times a week **Weeks 3-4:** Inject 11mcg three times a week **Weeks 5 and Onward:** Inject 22mcg three times a week ❑ **44mcg Directions:** **Weeks 1-2:** Inject 8.8mcg three times a week **Weeks 3-4:** Inject 22mcg three times a week **Weeks 5 and Onward:** Inject 44mcg three times a week	1 Pack	
❑ TECFIDERA®	❑ Tecfidera® 30-Day Starter Pack *(contains fourteen 120mg capsules and forty-six 240mg capsules)*	❑ **Starter Pack:** **Week 1:** Take one 120mg capsule by mouth twice a day **Week 2:** Take one 240mg capsule by mouth twice a day	1 Pack	0
	❑ 120mg Capsules ❑ 240mg Capsules	❑ Take one 120mg capsule by mouth twice a day	14	
		❑ Take one 240mg capsule by mouth twice a day	60	
❑ _____ ❑ _____ ❑ _____	❑ _____ ❑ _____ ❑ _____	❑ _____ ❑ _____ ❑ _____		

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.

IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions:_____