MULTIPLE SCLEROSIS ORAL MEDICATION REFERRAL FORM

CureStat Rx
Home Infusion and Specialty Pharmacy

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Insurance Information (please fax a copy of front and back of the insurance card(s))

Primary Insurance:_____ Plan ID: _____BIN #:_____ PCN #: _____ Grp #: _____
Secondary Insurance:_____ Plan ID: _____BIN #:_____ PCN #: _____ Grp #: _____

Clinical Information (Please fax pertinent lab information)

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ Other (ICD-10 code with description): _____ Diagnosis Date: __ __/__ __/__ __ __ __
Type: ☐ Primary-progressive ☐ Secondary-progressive ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Progressive-relapsing
Has pregnancy been excluded:☐ Yes ☐ No ☐ Not Applicable Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in
Hepatic impairment present: ☐ Yes ☐ No AST: _____U/L ALT: _____U/L Bilirubin: _____mg/dL Lab date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of therapy	Start date	End Date

Allergies: ☐ NKDA ☐ Other: _____
Comorbidities: _____
Concomitant Medications: _____

Drug	Dose/Strength	Directions	Qty	Refills
☐ **AUBAGIO** (teriflunomide)	☐ 7mg tab ☐ 14mg tab	☐ Take one tablet by mouth once a day		
☐ **AMPYRA** (dalfampridine)	☐ 10mg Tab	☐ Take one tablet by mouth twice daily (12 hours apart) ☐ Other: _____		
☐ **GILENYA** (Fingolimod)	☐ 0.25mg Capsule ☐ 0.5mg Capsule	☐ Patients weighing ≤ 40kg: Take 0.25mg by mouth once daily ☐ Patients weighing >40kg: Take 0.5mg by mouth once daily		
☐ **TECFIDERA** (Dimethyl Fumarate)	☐ 120mg Capsule ☐ 240mg Capsule	☐ Starter dose: Take one 120 mg capsule by mouth twice a day for 7 days, followed by one 240 mg capsule by mouth twice a day. ☐ Maintenance dose: Take 240mg by mouth twice a day Other: _____		

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____