MULTIPLE SCLEROSIS SELF INJECTABLE 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: _____

Please fax a copy of front and back of the insurance card(s).

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
☐ **AVONEX** (Interferon beta-1a)	☐ 30mcg Vial ☐ 30mcg/0.5mL prefilled syringe ☐ 30mcg/0.5mL prefilled autoinjecto	☐ **Starter Pack** 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		
		☐ **Maintenance dose:** Inject 30 mcg intramuscularly once weekly		
☐ **BETASERON** (Interferon beta-1b) ☐ **EXTAVIA** (interferon beta-1b)	☐0.3mg Vial	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) SC every other day ☐ Week 3-4: Inject 0.125 mg (0.5 mL) SC every other day		
		☐ Week 5-6: Inject 0.1875 mg (0.75 mL) SC every other day ☐ Week 7-8: Inject 0.25 mg (1 mL) SC every other day		
		☐ Inject 0.25 mg (1 mL) SC every other day		
☐ **GLATIRAMER ACETATE** ☐ **COPAXONE** ☐ **GLATOPA**	☐ 20mg/mL prefilled syringe ☐ 40mg/mL prefilled syringe	☐ Inject 20 mg SC once daily ☐Inject 40 mg SC three times per week at least 48 hours apart		
☐ **PLEGRIDY** (peginterferon beta-1a)	☐ Pen starter pack ☐ Prefilled Syringe starter pack ☐ 125mcg/0.5mL prefilled pen ☐ 125mcg/0.5mL prefilled syringe	☐ Starter Dose: Inject 63mcg SC on Day1 followed by 94mcg SC on Day 15		
		☐ Inject 125mcg SC every 14 days		
☐ **REBIF** (interferon beta-1a)	☐ 22mcg/0.5mL prefilled syringe ☐ 44mcg/0.5mL prefilled syringe ☐ 22mcg/0.5mL Autoinjector ☐ 44mcg/0.5mL Autoinjector	☐ Inject 22mcg SC three times per week ☐ Inject 44mcg SC three times per week ☐ Other: _____		

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____