US Bioservices
AmerisourceBergen

Multiple Sclerosis Referral Form (A-M)

Phone: (866) 916-0578
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: ________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: ________

1. Patient Information

Last Name: ________ Home Phone: ________ Work / Mobile Phone: ________
First Name: ________ Home Address: ________
S.S.#: ________ Date of Birth: ________ City: ________ State: ________ Zip: ________
Guardian / Caregiver: ________ Sex: ☐ Male ☐ Female Height: ________ Weight: ________ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and medical)

Medical Insurance: ________ Phone: ________ Prescription Card: ________ Phone: ________
Subscriber Name: ________ Policy #: ________ BIN / PCN: ________
Policy #: ________ Group #: ________ Medicare #: ________ Medicaid #: ________

3. Prescriber Information

Prescriber Name: ________ ☐ MD ☐ DO ☐ NP ☐ PA License #: ________ NPI #: ________ DEA #: ________
Practice Name: ________ Phone: ________ Fax: ________
Address: ________ Office Contact: ________ Phone: ________
City: ________ State: ________ Zip: ________ Collaborating Physician: ________

4. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies: ________
Meds Tried / Failed: ________
Current Medications: ________
Does MRI show features consistent with a MS diagnosis? ☐ Yes ☐ No
Is this the first clinical episode of MS for this patient? ☐ Yes ☐ No
Is the patient's functional status ambulatory? ☐ Yes ☐ No

☐ Multiple Sclerosis (ICD-10 Code: G35)
Relapsing Remitting (RRMS) ☐ Progressive Relapsing (PRMS)
☐ Primary Progressive (PMS) ☐ Secondary Progressive (SPMS)
☐ Other ICD-10 Diagnosis Code: ________
Other Disease States: ________

5. Prescription Information

Medication	Dose / Strength	Directions	Dispense	Refills
AMPYRA®	☐ 10 mg tablets	• Take 10 mg PO twice daily	**60 tablets**	
AVONEX®	☐ 30 mcg PFS ☐ 30 mcg PFS autoinjector	• Inject 30 mcg/0.5 mL IM every 7 days	**1 box**	
BETASERON®	☐ 0.3 mg LYO SDV	☐ Dose titration: • Weeks 1-2: Inject 0.0625 mg SC QOD • Weeks 3-4: Inject 0.125 mg SC QOD • Weeks 5-6: Inject 0.1875 mg SC QOD • Weeks 7+: Inject 0.25 mg SC QOD	**1 box**	**1**
		☐ Maintenance dose: Inject 1 mL (0.25 mg) SC QOD	**1 box**	
COPAXONE®	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg/mL SC QD ☐ Inject 40 mg/mL SC TIW, at least 48 hours apart	**1 box**	
EXTAVIA®	☐ 0.3 mg LYO SDV	☐ Dose titration: • Weeks 1-2: Inject 0.0625 mg SC QOD • Weeks 3-4: Inject 0.125 mg SC QOD • Weeks 5-6: Inject 0.1875 mg SC QOD • Weeks 7+: Inject 0.25 mg SC QOD	**1 box**	**1**
		☐ Maintenance dose: Inject 1 mL (0.25 mg) SC QOD	**1 box**	
GLATOPA®	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg/mL SC QD ☐ Inject 40 mg/mL SC TIW, at least 48 hours apart	**1 box**	
GILENYA®	☐ 0.5 mg capsules	☐ Take 0.5 mg PO QD ☐ Take 0.25 mg PO QD	**30 capsules**	
KESMIPTA	☐ 20 mg/0.4mL PFP	☐ Initial dose: Inject 20 mg SC at weeks 0, 1, and 2	**2 boxes**	**0**
		☐ Maintenance dose: Inject 20 mg SC monthly starting at week 4	**1 box**	
MAYZENT®	☐ 0.25 mg tablets ☐ 2 mg tablets	☐ Dose titration to 1 mg: • Day 1-2: Take 0.25 mg PO QD • Day 3: Take 0.50 mg PO QD • Day 4: Take 0.75 mg PO QD • Day 5+: Take 1 mg PO QD ☐ Dose titration to 2 mg: Reference www.mayzenthcp.com for the "Start Form" or call (877) 629-9368 for the starter pack		
		Maintenance dose: ☐ Take 1 mg PO QD ☐ Take 2 mg PO QD		

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature ________ Date ____ / ____ / ____

Account Manager

____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

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Policy #: ________ Group # : ________ Medicare #: ________ Medicaid #: ________

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☐ Other ICD-10 Diagnosis Code: ________
Other Disease States: ________

5. Prescription Information

Medication	Dose / Strength	Directions	Dispense	Refills
OCREVUS®	☐ 300 mg/1 mL SDV	☐ Initial dose: Infuse 300 mg IV, followed two weeks later by a second 300 mg infusion	**2 vials**	
		☐ Maintenance dose: Infuse 600 mg IV Q6 months	**2 vials**	
PLEGRIDY® Titration Pack	☐ Starter PFS ☐ Starter Pen	• Inject 63 mcg SC on day 1, followed by 94 mcg on day 2, and then 125 mcg on day 29	**1 box**	**0**
PLEGRIDY®	☐ 125 mcg/0.5 mL Pen ☐ 125 mcg/0.5 mL PFS	• Inject 125 mcg SC Q14D	**1 box**	
REBIF® Titration Pack	☐ PFS ☐ Rebidose autoinjector	☐ 22 mcg dosing (PFS Only) • Weeks 1-2: Inject 4.4 mcg SC TIW • Weeks 3-4: Inject 11 mcg SC TIW	**1 pack**	**0**
		☐ 44 mcg dosing • Weeks 1-2: Inject 8.8 mcg SC TIW • Weeks 3-4: Inject 22 mcg SC TIW	**1 pack**	**0**
REBIF®	☐ 22 mcg autoinjector ☐ 22 mcg PFS ☐ 44 mcg autoinjector ☐ 44 mcg PFS	☐ Inject 22 mcg SC TIW ☐ Inject 44 mcg SC TIW	**1 box**	
TECFIDERA®	☐ 30-day starter pack	• Take 120 mg PO BID x 7 days + 240 mg PO BID x 23 days	**1 pack**	**0**
	☐ 120 mg capsules	• Take 120 mg PO BID	**56 capsules**	
	☐ 240 mg capsules	• Take 240 mg PO BID x 30 days	**60 capsules**	
VUMERITY®	☐ 231 mg DR capsules	☐ Initial dose: Take 231 mg PO BID x 7 days, then 462 mg PO BID thereafter	**106 capsules**	**0**
		☐ Maintenance dose: Take 462 mg PO BID	**120 capsules**	
ZEPOSIA®	☐ 0.92 mg capsules	☐ Maintenance dose: Take 0.92 mg PQ QD	**30 capsules**	

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I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____