ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

MULTIPLE SCLEROSIS REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Today's Date ______ Anticipated Start Date ______

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name ______ Middle Name ______ Last Name ______ DOB ______ Weight ______ ☐ Male ☐ Female

Street Address ______ Apt # ______ City ______ State ______ Zip ______

Daytime Tel ______ Evening Tel ______ Cell ______ Email ______

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ______

ICD-9 Diagnosis Code ☐ 340 Multiple Sclerosis **OR** Other ______ Allergies ______

Patient currently on therapy ☐ Yes ☐ No Date of next blood work ______ Comments ______

Insured's Name ______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______

Prescription Card ☐ Yes ☐ No If Yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______

Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______

Street Address ______ Suite # ______ City ______ State ______ Zip ______

Tel ______ Fax ______ Email ______

License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AVONEX ADMINISTRATION PACK 30mcg PreFilled

SIG ☐ Inject 30mcg IM once weekly
☐ Other ______
QTY # ______ Weeks *(1 pack = 4 week supply)* Refills x ______

BETASERON 0.3mg Vials

SIG ☐ Inject ______ SC every other day
☐ Other ______
QTY # ______ Weeks *(1 box = 4 week supply)* Refills x ______

COPAXONE 20mg/2ml Syringe

SIG ☐ Inject 20mg (2ml) SC once daily
☐ Other ______
QTY # ______ Syringes Refills x ______

REBIF TITRATION PACK 12 syringes

SIG ☐ 8.8mcg SQ TIW - weeks 1 & 2 ☐ 22mcg SQ TIW - weeks 3 & 4
Maintenance Dose following week 3 & 4
QTY # ______ Boxes *(1 box = 4 week supply)* Refills x ______

REBIF 22mcg/0.5ml

SIG ☐ 22mg (0.5ml) SQ TIW (48hrs apart)
QTY # ______ Boxes *(1 box = 4 week supply)* Refills x ______

REBIF 44mcg/0.5ml (maintenance)

SIG ☐ starting week 5: 44mcg (0.5ml) SQ TIW (48hrs apart)
QTY # ______ Boxes *(1 box = 4 week supply)* Refills x ______

OTHER ______

SIG ______ QTY ______ Refills x ______

GILENYA 0.5 mg ______orally once daily QTY - 28 Refill X ______

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

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