MedicoRx Specialty
& HOME INFUSION PHARMACY

Multiple Sclerosis
REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information	Prescriber information
Name: **DOB:**	**Prescriber's Name:**
Address: **City, State, Zip**	**NPI#** **DEA#** **License#**
Phone # **Alt#** **SSN:**	**Address** **City, State, Zip**
Height: **Wt:** **Allergies:**	**Phone #** **Fax #**
Emergency Contact/ Phone #	**Contact Person:**

Clinical Considerations

Diagnosis (ICD 10) : □ G35 Multiple Sclerosis □ Other (please specify)_________________________________

Prior Therapies

Expected date of injection _____/_______/________ Last injection date _____/______/_______

Date of pregnancy test ______/________/_________ Results □ + □ -

	LEVF	Platelets	ANC	Bilirubin
Result:				
Date:				

Drug Name	Strength/Directions for use		Refills
Avonex® (interferon beta 1-a)	□ 30mcg pre-filled syringe	□ Inject 30mcg SC once weekly □ ______________________________________	
Copaxone® (glatiramer acetate)	□ 20mg pre-filled syringe □ 40mg pre-filled syringe	□ Inject 20mg SC once daily □ Inject 40mg SC TIW □ ______________________________________	
Gilenya® (fingolimod)	□ 0.5mg capsule	1 capsule by mouth daily □ ______________________________________	
Rebif® (interferon beta-1a)	□ 22mcg prefilled syringe □ 44mcg prefilled syringe	□ Inject 22mcg SC three times weekly □ Inject 44mcg SC three times weekly □_______________________________________	

□ 4 week supply REFILL_____________ times

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this □ DAW___ **Date**