PerformSpecialty®

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Multiple Sclerosis Referral Form

Fax: 1-844-489-9565 | Phone: 1-855-287-7888 | www.performspecialty.com

Patient

Patient name:			
Date of birth:	□ Male □ Female	Height:	Weight: lb kg
Address:		City:	State: ZIP:
Home number:	Work number:	Cell number:	Best time to call: □ a.m. □ p.m.
Last 4 of Social Security:		Ethnicity:	
Primary language:	Allergies:		□ No known drug allergies

Provider

Physician name:	Practice name:	
National Provider Identifier (NPI) number:	State license number:	
Address:	City:	State: ZIP:
Drug Enforcement Administration (DEA) number:	Phone:	Fax:
Key office contact:		Phone:

Insurance

***Please provide a copy of the insurance card (front and back).**

Clinical information

Diagnosis: □ G35 (Multiple Sclerosis) □ Other ICD:	Diagnosis Date:
Type: □ Relapsing-remitting □ Secondary-progressive □ Primary-progressive □ Progressive-relapsing □ Clinically isolated syndrome	
Previously treated: □ Avonex □ Betaseron □ Copaxone □ Gilenya □ Plegridy □Rebif □Other:__________	Dates:

Please attach copes of pertinent labs and clinicals in order to assist us in obtaining prior authorization approval.

Prescription information

Medication	Dose/Strength	SIG	Quantity	Refills
❑ Aubagio®	□ 7 mg Tab □ 14mg Tab	□ Take one tablet by mouth once daily.	1 month supply	
❑ Avonex®	30 mcg □ Pen □ PFS □ Vial	□ Dose Titration: (PFS Only) • Week 1: Inject 7.5mcg IM once weekly Week 2: Inject 15mcg IM once weekly • Week 3: Inject 22.5mcg IM once weekly • Week 4+: Inject 30mcg IM once weekly thereafter. □ Maintenance Dose: Inject 30mcg IM once weekly	1 month supply	
❑Dalfampridine	□ 10 mg tablets	□ Take one tablet by mouth once daily.	1 month supply	
❑ Betaseron® ❑ Extavia®	□ 0.3 mg vial	□ Dose Titration: • Weeks 1 – 2: Inject 0.0625mg/0.25mL SubQ every other day • Weeks 3 – 4: Inject 0.125mg/0.50mL SubQ every other day • Weeks 5 – 6: Inject 0.1875mg/0.75mL SubQ every other day • Weeks 7+: Inject 0.25mg/1mL SubQ every other day □ Maintenance dose: Inject 0.25mg SubQ every other day	1 month supply	
❑ Copaxone® ❑ Glatiramer ❑ Glatopa	□ 20 mg PFS □ 40 mg PFS	□ Inject 20mg SubQ once daily □ Inject 40mg SubQ three times a week, at least 48 hours apart on the same three days each week	1 month supply	
❑ Gilenya®	□ 0.5 mg capsule	□ Take one capsule by mouth daily with or without food	1 month supply	
❑ Ocrevus™	□ 300 mg/10ml vial	□ Infuse 300 mg IV on day 1, followed by 300 mg IV infusion 2 weeks later □ Infuse 600 mg IV administered once every 6 months (beginning 6 months after the first 300 mg dose).	□ 1 vial □ 2 vials	
❑ Plegridy®	□ 63mcg/94mcg Starter Pak □ 125mcg □Pen □PFS	□ Initial dose: Inject 63mcg SubQ day 1, then 94mcg SubQ day 15 □ Maintenance dose: Inject 125mg SubQ on day 29 and then every two weeks thereafter	1 month supply □ Starter Kit	
❑ Rebif®	□ PFS Starter □ Pen Starter □22mcg PFS □ 22mcg Pen □44mcg PFS □ 22mg Pen	□ Titration Pack 22mcg Weeks 1-2: Inject 4.4mcg SubQ three times weekly. Weeks 3-4: Inject 11mcg SubQ three times weekly. □ Titration Pack 44mcg Weeks 1-2: Inject 8.8mcg SubQ three times weekly. Weeks 3-4: Inject 22mcg SubQ three times weekly □ Maintenance Dose: □22mcg □44mcg SubQ three times weekly	1 month □ Starter kit	
❑ Tecfidera™	□Titration Pack □ 120mg Cap □ 240mg Cap	□Titration Pack -Take 120 mg capsule by mouth twice a day for 7 days followed by 240 mg capsule by mouth twice a day □ Maintenance Dose: Take 240mg capsule by mouth twice daily	1 month □ Starter Kit	
❑Mayzent	□ 0.25mg Tab □ 2mg Tab	□ Take 2 mg once daily, beginning on Day 6. □Take 1 mg once daily, beginning on Day 5	1 month	
❑ Other				

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS. (STAMPS NOT ACCEPTED)	
Prescriber signature:	Prescriber signature:
□ Dispense as written/Do not substitute Date:	□ Substitution permitted/Branded exchange permitted Date:

For states requiring handwritten expressions of product selection, use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).

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