BIOMATRIX SpRx

MULTIPLE SCLEROSIS REFERRAL FORM

TODAY'S DATE _____

☐ **CURRENT PATIENT** ☐ **NEW PATIENT**

PLEASE FAX REFERRAL FORM TO:

- ☐ **BiologicTx - NJ** TEL: 877-567-8087 FAX: 877-567-8089
- ☐ **BiologicTx - CA** TEL: 800-404-1963 FAX: 800-404-4595
- ☐ **BiologicTx - IL** TEL: 888-892-7607 FAX: 877-567-8089
- ☐ **Decillion Healthcare** TEL: 800-622-9321 FAX: 866-548-8849
- ☐ **Elwyn Specialty Care** TEL: 855-359-9679 FAX: 610-545-6030
- ☐ **Factor Support Network** TEL: 877-376-4968 FAX: 805-482-6324
- ☐ **Matrix Health** TEL: 877-337-3002 FAX: 888-385-2805
- ☐ **Med Center Specialty Pharmacy** TEL: 855-633-5633 FAX: 304-344-0655
- ☐ **MedEx BioCare** TEL: 800-962-6339 FAX: 901-382-3091

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____

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# _____

ICD-10 Diagnosis Code ☐ G35 Multiple Sclerosis OR ☐ Other_____ Patient Weight_____
Patient currently on therapy ☐ Yes ☐ No Date of next blood work_____
Comments_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AUBAGIO**
SIG: ☐ 7 mg: 1 tablet by mouth daily with or without food
SIG: ☐ 14 mg: 1 tablet by mouth daily with or without food
QTY:_____ Refills: _____

AVONEX ADMINISTRATION PACK
☐ **30 mcg PreFilled Syringe** ☐ **30 mcg Autoinject Pen**
SIG: ☐ Inject 30 mcg IM once weekly
SIG: ☐ Other _____
QTY: # _____ (1 pack = 4 week supply) Refills: _____

☐ **BETASERON 0.3 mg Vials**
SIG: ☐ Inject _____ subcutaneously every other day
SIG: ☐ Other _____
QTY: # _____ (1 box = 4 week supply) Refills: _____

COPAXONE ☐ **20 mg Syringe** ☐ **40 mg Syringe**
SIG: ☐ Inject 20 mg subcutaneously once daily
SIG: ☐ Inject 40 mg subcutaneously three times a week
SIG: ☐ Other _____
QTY:_____ Refills: _____

☐ **EXTAVIA VIALS 0.3 mg**
SIG: ☐ Inject _____ subcutaneously every other day
SIG: ☐ Other _____
QTY: # _____ (1 box = 4 week supply) Refills: _____

☐ **GILENYA 0.5 mg** *(first dose must be taken at the doctor's office)*
SIG: ☐ Take 1 Capsule by mouth daily QTY:_____ Refills: _____

☐ **LEMTRADA 12mg/1.2mL**
SIG: _____QTY:_____ Refills: _____

☐ **OCREVUS 300 mg/10 mL**
Loading Dose: Infuse 300 mg IV on Day 1 followed by 300 mg IV 2 weeks later QTY: 2 Vials
Maintenance Dose: Infuse 600 mg IV once every 6 months (beginning 6 months after first 300 mg dose)
QTY:_____ Refills: _____

REBIF TITRATION PACK 12 syringes
SIG: ☐ 8.8 mcg subcutaneously TIW - weeks 1 & 2
SIG: ☐ 22 mcg subcutaneously TIW - weeks 3 & 4
Maintenance Dose following week 3 & 4

☐ **REBIF 22 mcg/0.5ml**
SIG: 22 mcg (0.5ml) subcutaneously TIW (48hrs apart)
QTY:_____ Refills: _____

☐ **REBIF 44 mcg/0.5ml (maintenance starting week 5)**
SIG: 44 mcg (0.5ml) subcutaneously TIW (48hrs apart)
QTY # _____ Boxes *(1 box = 4 week supply)* Refills: _____

☐ **TYSABRI 300mg IV**
SIG: ☐ Infuse 300mg IV over 1 hour every 4 weeks
QTY:_____ Refills: _____

OTHER _____
SIG _____
QTY _____ Refills _____

OTHER _____
SIG _____
QTY _____ Refills _____

▬ = Restricted access medication as of November 2013

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ *Dispense as written* **Date**_____

Prescriber's Signature (signature required. NO STAMPS)_____ *Product Substitution Permitted* **Date**_____

Please visit **WWW.BIOMATRIXSPRX.COM** For more information