

PATIENT REFERRAL FORM

(electronically transmitted prescription)

Prescriber: _____, M.D. DEA# _____

Address: _____

() _____ - _____ (ph) () _____ - _____ (fax) DATE: _____

REQUIRED! Date Need by: _____ Deliver to: Patient MD Office Other: _____

PATIENT INFO Attach copy of patient's demographic sheet or complete

Patient Name _____ Home Phone _____

Address _____ Daytime Phone _____

City _____ State _____ Zip _____ DOB _____ SSN _____

INSURANCE INFO. Attach copy of patient's Insurance card (both sides), insurance info. from medical record or complete.

Primary Insurance _____ Secondary Insurance _____

Name of Insured _____ Name of Insured _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Phone # _____ Phone # _____

MEDICAL HISTORY/INFO

ICD-9 Codes 340 Multiple Sclerosis Allergies _____

PRESCRIPTIONS

Avonex Administration Pack 30mcg PreFilled

SIG: Inject 30mcg IM Once Weekly

(other)

Quantity
_____ Weeks
(Each pack is a 4-week supply)
REFILLS X _____

Betaseron 0.3mg Vials

SIG: Inject _____ SC every other day

(other)

Quantity
_____ Weeks
(Each box is a 4-week supply)
REFILLS X _____

Copaxone 20mg/2ml Syringe

SIG: Inject 20mg (2ml) SC once daily.

(other)

Quantity
_____ Syringes
REFILLS X _____

Novantrone 2mg/1ml Syringe

SIG: MD to Infuse 12mg/m² Dose = _____ mg / _____ ml IV every 3 months Does PT have S/S of CHF? Y N
Patient Height = _____ cm Patient Weight = _____ kg m² = _____ x _____ mg = Dose _____
 Neutrophil Count in excess of 1500 cells/ mm³ Total cumulative Dose **including** this dose = _____ mg/m² REFILLS X _____
(*Total Cumulative Dose should NOT Exceed 140mg/m²)

Quantity
_____ Syringes

Rebif Syringe

SIG: 22mcg/0.5ml Inject _____ SC 3 times per week
 44mcg/0.5ml Inject _____
(Other)

Quantity
_____ Boxes
(Each box is a 4-week supply)
REFILLS X _____

Additional Meds

Item

Quantity

_____ # _____ REFILLS X _____
_____ # _____ REFILLS X _____

Physician Signature _____

Interchange is mandated unless the practitioner writes the words "no substitution" in the above space

FAX COVER SHEET



315 Pleasant Street
Building 1, 6th floor
Fall River, MA 02721
800-218-5688 (phone)

800-830-5292 (fax)

ATTENTION: Please remember to include the Need by Date and delivery location to help us deliver your patient's order on time.

Date: _____

Senders Name: _____

Direct Phone #: _____

My fax # is: _____

We are transmitting a total of _____ pages, including this cover page.

Additional Notes: