Sterling SPECIALTY PHARMACY

Multiple Sclerosis
Prescription Referral Form (A to G)

NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: _____ Birthdate: _____ Sex: ❑ Male ❑ Female Height: _____ Weight: _____ ❑ lbs. ❑ kg.

Allergies: _____ Patient Primary Language: ❑ English ❑ Spanish ❑ Other: _____ ❑ Hearing Impaired

Patient Phone: _____ Patient Email: _____ Caregiver Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

2 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Diagnosis/ICD-10: _____ Diagnosis Date: _____ Other: _____

❑ Relapse/Remitting ❑ Progressive

If Relapse Remitting: Has the patient experienced a first clinical episode? ❑ Yes ❑ No

❑ Attach MRI Results Date: _____

Does the patient have any contraindication(s) to therapy? ❑ Yes ❑ No

If Yes: _____

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
❑		
❑		
❑		
❑		

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
❑ AMPYRA®	❑ 10mg Tablets	❑ Take one tablet by mouth twice daily with, or without, food. **Note: Medication request should be sent to Ampyra hub via ampyra-hcp.com using the Medication Request Form.** ❑ Other: _____	❑ 60 ❑ ____	❑ ____
❑ AUBAGIO®	❑ 7mg Tablets ❑ 14mg Tablets	❑ Take one tablet by mouth once daily with, or without, food. ❑ Other: _____	❑ 30 ❑ ____	❑ ____
❑ AVONEX®	❑ 30mcg Prefilled Syringe ❑ 30mcg Single Dose Vial ❑ 30mcg Avonex® Pen	❑ Inject 30mcg IM once a week. ❑ **Tritration:** 7.5mcg weekly (over a 4 week period) until target dose of 30mcg is reached. ❑ Other: _____	❑ 1 Pack ❑ ____	❑ ____
❑ BETASERON®	❑ 0.3mg Lyophilized Powder	❑ Inject 0.25mg (1ml) SQ every other day. ❑ **Tritration:** **Weeks 1 – 2:** Inject 0.0625mg (0.25ml) SQ every other day. **Weeks 3 – 4:** Inject 0.125mg (0.50ml) SQ every other day. **Weeks 5 – 6:** Inject 0.1875mg (0.75ml) SQ every other day. **Weeks 7 and Onward:** Inject 0.25mg (1ml) SQ every other day. ❑ Other: _____	❑ 1 Pack ❑ ____	❑ ____
❑ COPAXONE®	❑ 20mg Prefilled Syringe ❑ 40mg Prefilled Syringe	❑ Inject 20mg SQ daily. ❑ Inject 40mg SQ three times per week. ❑ Other: _____	❑ 1 Pack ❑ ____	❑ ____
❑ EXTAVIA®	❑ 0.3mg Lyophilized Powder	❑ Inject 0.25mg (1ml) SQ every other day. ❑ **Tritration:** **Weeks 1 – 2:** Inject 0.0625mg (0.25ml) SQ every other day. **Weeks 3 – 4:** Inject 0.125mg (0.50ml) SQ every other day. **Weeks 5 – 6:** Inject 0.1875mg (0.75ml) SQ every other day. **Weeks 7 and Onward:** Inject 0.25mg (1ml) SQ every other day. ❑ Other: _____	❑ 1 Pack ❑ ____	❑ ____
❑ GILENYA®	❑ 0.25mg Capsules ❑ 0.50mg Capsules	❑ **Patients 10 years of age or older and weighing > 40kg:** Take one 0.50mg capsule by mouth once daily with, or without, food. ❑ **Patients 10 years of age or older and weighing ≤ 40kg:** Take one 0.25mg capsule by mouth once daily with, or without, food. ❑ Other: _____	❑ 30 ❑ ____	❑ ____
❑ GLATOPA™	❑ 20mg Prefilled Syringe	❑ Inject 20mg SQ daily. ❑ Other: _____	❑ 30 ❑ ____	❑ ____
❑ _____	❑ _____	❑ _____	❑ ____	❑ ____

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

Provider Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.