EAGLET PHARMACY

Multiple Sclerosis Referral Form

Toll Free Phone Number : 800-407-7421
Toll Free Fax Number : 800-308-8573

2209 SW 104th St Suite E, Oklahoma City, OK, 73159

This prescription form is to be sent & received via fax

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ___/___/___	SS#: ___-___-___
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other:	Wt.: Ht.:

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment

Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed

Other/Concomitant Medications (please list)

Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained

ICD-10 Codes ☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ B25 CMV disease ☐ B25.9 CMV disease, unspecified ☐ Other Code _____ Description _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Avonex®	☐ 30 mcg PFS ☐ 30 mcg Autoinjector	☐ Maintenance Dose: Inject 30 mcg (0.5 mL) IM every 7 days.	28-Day (1 Box)	
☐ Betaseron®	☐ 0.3 mg KIT (14 Vials)	☐ Dose Titration: • Weeks 1&2: Inject 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: Inject 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: Inject 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: Inject 0.25 mg (1 mL) SubQ every other day	1 Box	1
		☐ Maintenance Dose: Inject 0.25 mg (1 mL) SubQ every other day	28-day	
☐ Briumvi	☐ 150 mg	☐ Starting Dose: 150 mg on day 1, followed by 450 mg once 2 weeks later	3 Vials	
		☐ Maintenance Dose: 450 mg once every 24 weeks	3 Vials	
☐ Copaxone®	☐ 20 mg PFS	☐ Inject 20 mg SubQ once daily	30-day	
	☐ 40 mg PFS	☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-day	
☐ Dalfampridine ER	☐ 10 mg Tablet	☐ Take 10 mg by mouth twice daily, approximately 12 hours apart.	30-day	
☐ Extavia®	☐ 0.3 mg KIT (15 Vials)	☐ Dose Titration: • Weeks 1&2: Inject 0.0625 mg (0.25 mL) SubQ every other day • Weeks 3&4: Inject 0.125 mg (0.5 mL) SubQ every other day • Weeks 5&6: Inject 0.1875 mg (0.75 mL) SubQ every other day • Weeks 7+: Inject 0.25 mg (1 mL) SubQ every other day	1 Box	1
		☐ Maintenance Dose: Inject 0.25 mg (1 mL) SubQ every other day	30-day	
☐ Gilenya® **indicate First Dose Observation (FDO) status*	☐ 0.5 mg capsule	☐ Take 0.5 mg by mouth once daily. ☐ Continuation of therapy; FDO completed ☐ FDO planned – Date: _____	30-day	
☐ Glatiramer Acetate	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg SubQ once daily	30-Day	
		☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-Day	
☐ Glatopa	☐ 20 mg PFS ☐ 40 mg PFS	☐ Inject 20 mg SubQ once daily	30-Day	
		☐ Inject 40 mg SubQ three times weekly, at least 48 hours apart on the same 3 days each week	28-Day	

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Eaglet Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date:** ___/___/___

CONFIDENTIALITY NOTICE

EAGLET PHARMACY

Multiple Sclerosis Referral Form

Toll Free Phone Number : 800-407-7421
Toll Free Fax Number : 800-308-8573

2209 SW 104th St Suite E, Oklahoma City, OK, 73159

This prescription form is to be sent & received via fax

Prescriber:		**NPI:**	
Supervising Physician:		**NPI:**	
Address:		**Tax ID:**	
Phone:		Fax:	
Contact:			

PATIENT INFORMATION

Name:	○ M ○ F ○ Trans M ○ Trans F ○ Other	DOB: ___/___/___	SS#: ___-___-___
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	○ English ○ Spanish ○ Other:	Wt.: Ht.:

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			
Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)		☐ Other (please list)	
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	

ICD-10 Codes ☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ B25 CMV disease ☐ B25.9 CMV disease, unspecified ☐ Other Code _____ Description _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Kesimpta *HBV & quantitative serum Ig screening required before 1st dose*	☐ 20 mg Autoinjector	☐ Loading Dose: Inject 20 mg (0.4 mL) SubQ at Weeks 0, 1 and 2.	3 Units	0
		☐ Maintenance Dose: Inject 20 mg (0.4 mL) SubQ monthly starting at week 4.	1 Unit	
☐ Mayzent *1 mg daily dosing*	☐ 0.25 mg tablets	☐ Dose Titration to 1 mg: • Day 1&2: Take 0.25 mg PO once daily • Day 3: Take 0.50 mg PO once daily • Day 4: Take 0.75 mg PO once daily • Day 5+: Take 1 mg PO once daily	12 Tablets	0
		☐ Maintenance Dose: Take 1 mg PO once daily	28-Day	
☐ Mayzent *2 mg daily dosing*	☐ 2 mg tablets	☐ Dose Titration to 2 mg: Reference www.mayzenthcp.com for the "Start Form: or call 877.629.9368 for the starter pack		
		☐ Maintenance Dose: Take 2 mg PO once daily.	30-Day	
☐ Ocrevus™	☐ 300 mg/10 mL SDV	☐ Initial Dose: Infuse 300 mg IV on Day 1, followed by a second 300 mg IV infusion two weeks later	2 Vials (6 Months)	0
		☐ Maintenance Dose: Infuse 600 mg IV once every six months (begin 6 months after the first 300 mg dose)	2 Vials (6 Months)	
☐ Plegridy® *Starter Pack*	☐ PFS ☐ Autoinjector	☐ IM Initial Dose: Inject 63mcg IM on day 1 then inject 94mcg IM on day 15 ☐ SubQ Initial Dose: Inject 63mcg SubQ on day 1 then inject 94mcg SubQ on day 15	28-day	
☐ Plegridy® *Maintenance Dose*	☐ 125 mcg (PFS) ☐ 125 mcg (Autoinjector)	☐ IM Maintenance Dose: Inject 125mcg (0.5ml) IM every 14 days ☐ SubQ Maintenance Dose: Inject 125mcg (0.5ml) SubQ every 14 days	28-Day	

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Eaglet Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date:** ___/___/___

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

EAGLET PHARMACY

Multiple Sclerosis Referral Form

Toll Free Phone Number : 800-407-7421
Toll Free Fax Number : 800-308-8573

2209 SW 104th St Suite E, Oklahoma City, OK, 73159

This prescription form is to be sent & received via fax

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	○ M ○ F ○ Trans M ○ Trans F ○ Other	DOB: ___/___/___	SS#: ___-___-___
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	○ English ○ Spanish ○ Other:	Wt.: Ht.:

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment

Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed

Other/Concomitant Medications (please list)

Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained

ICD-10 Codes ☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ B25 CMV disease ☐ B25.9 CMV disease, unspecified ☐ Other Code _____ Description _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Rebif® *Titration Pack Initial Dosing*	☐ PFS ☐ Rebidose Autoinjector Titration Packs Contain: 6x8.8 mcg devices 6x22mcg devices	☐ Loading Dose (22 mcg target dose) (PFS Only): • Weeks 1&2: Inject 4.4 mcg SubQ three times weekly • Weeks 3&4: Inject 11 mcg SubQ three times weekly • Weeks 5+: Inject 22 mcg SubQ three times weekly Separate doses by at least 48 hours.	1 Pack (28-Day)	0
		☐ Loading Dose (44 mcg target dose): • Weeks 1&2: Inject 8.8 mcg SubQ three times weekly • Weeks 3&4: Inject 22 mcg SubQ three times weekly • Weeks 5+: Inject 44 mcg SubQ three times weekly Separate doses by at least 48 hours.	1 Pack (28-Day)	0
☐ Rebif *Maintenance Dosing*	☐ 22 mcg Autoinjector ☐ 22 mcg PFS	☐ Maintenance Dose: Inject 22 mcg (0.5 mL) SubQ three times weekly. Separate doses by at least 48 hours.	28-day	
	☐ 44 mcg Autoinjector ☐ 44 mcg PFS	☐ Maintenance Dose: Inject 44 mcg (0.5 mL) SubQ three times weekly. Separate doses by at least 48 hours.	28-day	
☐ Tecfidera®	☐ Titration / Starter Pack 14 x 120 mg capsules 46 x 240 mg capsules	☐ Initial Dose: Take 120 mg by mouth twice daily for seven days. Then, take 240 mg by mouth twice daily.	30-day	
	☐ 240 mg capsule ☐ 120 mg capsule	☐ Maintenance Dose: Take 240 mg by mouth twice daily.	30-day	
		☐ Maintenance Dose: Take 120 mg by mouth twice daily.	28-Day	
☐ Vumerity™	☐ 231 mg capsule	☐ Initial Dose: Take 231 mg by mouth twice daily for seven days. Then, take 462 mg (2x231 mg) by mouth twice daily.	106 Capsules	0
		☐ Maintenance Dose: Take 462 mg (2x231 mg) by mouth twice daily.	30-day	
☐ Zeposia	☐ Starter Kit Kit contains: 4x0.23 mg caps 3x0.46 mg caps 30x0.92 mg caps	☐ Initial Dose: Days 1-4: Take one 0.23 mg capsule by mouth once daily x 4 days Days 5-7: Take one 0.46 mg capsule by mouth once daily x 3 days Day 8 and thereafter: Take one 0.92 mg capsule by mouth once daily	1 Kit	0
	☐ 0.92 mg Capsule	☐ Maintenance Dose: Take one capsule by mouth once daily	☐ 30-day	

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Eaglet Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date:** ___/___/___

CONFIDENTIALITY NOTICE