

Neurology Referral Form (Multiple Sclerosis)

Fax # **844-635-5250**

Patient Information:

Patient Name: _____ DOB: _____ SS#: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ Cell Phone: _____

Medical Assessment:

Diagnosis (ICD-10):

- ☐ G35.A Relapsing-remitting MS
- ☐ G35.B _____ (0,1, or 2) Primary progressive MS
- ☐ G35.C _____ (0, 1 or 2) Secondary progressive MS
- ☐ G35.D MS, unspecified
- ☐ G710.36 Limb-girdle muscular dystrophy
due to fukutin-related dysfunction

History:

Has the patient previously been treated for this condition?

☐ Yes ☐ No

Medications Failed: _____

Allergies: _____

Medication:

Betaseron

____ Load: Inject 0.0625mg subcutaneously every other day for weeks 1-2
Inject 0.125 mg subcutaneously every other day for weeks 3-4
Inject 0.1875 mg subcutaneously every other day for weeks 5-6
Inject 0.25 mg subcutaneously every other day for weeks 7 and thereafter

Quantity: _____

____ Maintenance: Inject 0.25mg (1ml) subcutaneously every other day
____ Other: _____

Quantity: _____ Refills _____

Dalfampridine 10mg ER (generic Ampyra)

____ Take one tablet twice daily every 12 hours
____ Other: _____

Quantity: _____ Refills _____

Dimethyl Fumarate (generic Tecfidera)

____ Load: Take 120mg by mouth twice daily for 7 days
____ Maintenance: Take 240mg by mouth twice daily

Quantity: _____

Quantity: _____ Refills _____

Glatiramer Acetate Injection (generic Copaxone)

____ Inject 20mg subcutaneously every day
____ Inject 40mg subcutaneously three times a week
____ addition of **WhisperJECT Autoinjector**

Quantity: 1 kit Refills _____

Quantity: 1 kit Refills _____

Kesimpta

____ Load: Inject 20mg subcutaneously at weeks 0,1,2
____ Maintenance: Inject 20mg subcutaneously monthly starting at week 4

Quantity: 3

Quantity: _____ Refills _____

Rebif

____ Titration:
____ 4.4 mcg (0.1ml) subcutaneously three times weekly for weeks 1-2
____ 11 mcg (0.25ml) subcutaneously three times weekly for weeks 3-4
or
____ 8.8 mcg (0.2ml) subcutaneously three times weekly for weeks 1-2
____ 22 mcg (0.5ml) subcutaneously three times weekly for weeks 3-4

Quantity: _____

____ Maintenance:
____ 22 mcg (0.5ml) subcutaneously three times weekly starting at week 5
or
____ 44 mcg subcutaneously three times weekly starting week 5
____ Other: _____

Quantity: 1 kit Refills _____

Teriflunomide (generic Aubagio)

____ Take one 7 mg tablet PO once daily
____ Take one 14 mg tablet PO once daily

Quantity: _____ Refills _____

Quantity: _____ Refills _____

Physician

Prescription Physician Name: _____ NPI: _____ Phone: _____ Fax: _____

Orders:

Address: _____ Date: _____ Nurse: _____

Physician Signature: _____