ACS Advanced Care Scripts

MS Care Referral Form

Phone: 877-985-MEDS(6 3 3 7) **Fax: 866-679-7131**

Contact your dedicated Account Rep:

Patient Demographic Information OR Attach Face Sheet

First Name	Middle Initial	Last Name	Date of Birth	Gender ☐ M ☐ F	Social Security Number

Street:					
City	State	Zip Code	Home Phone	Work Phone	Cell Phone

Insurance Information OR Attach Insurance information

Rx Card Insurance Name:	ID#	BIN:	PCN:	Group:	Phone:
Primary Insurance Name:	ID#:	Group#:			Phone:
Secondary Insurance Name:	ID#:	Group#:			Phone:

Drug List OR Attach Prescription

Drug Name	Form/Strength/Directions for Use	Qty	Refills
Aubagio (28ct box)	☐7mg ☐14mg ☐ 1 tablet by mouth once daily ☐ Other: _____		
Avonex	☐ 30mcg/0.5mL IM Q Week PFS ☐ 30mcg/0.5mL IM Q Week Pen ☐ 30mcg/1mL IM Q Week Vials ☐ Avonex short needles, 1" 25g ☐Other: _____		
Betaseron	☐ Initial dosing: Titration: Weeks 1-2 : 0.0625mg/0.25mL every other day SubQ then Weeks 3-4: 0.125mg/0.50mL every other day SubQ; Weeks 5-6: 0.1875mg/0.75mL every other day SubQ then Week 7+: 0.25 mg/1mL every other day SubQ ☐ Maintenance: 0.25mg SubQ every other day ☐ 1 year ☐Other: ___		
Copaxone (Glatopa)	☐ **Copaxone** 20 mg SubQ Once Daily OR ☐ **Glatopa** 20 mg SubQ Once Daily ☐ **Copaxone** 40mg SubQ TIW		
Extavia	☐ Initial dosing: Titration: Weeks 1-2 :0.0625 mg/0.25mL every other day SubQ then Weeks 3-4: 0.125mg/0.50mL every other day SUBQ: Weeks 5-6: 0.1875mg/0.75mL every other day SubQ then Week 7+: 0.25mg/1mL every other day SubQ ☐Maintenance: 0.25mg SubQ every other day ☐ Other: ___		
Gilenya	☐ 0.5mg daily by mouth ☐ 1 year		
Plegridy	☐Initial dose: 63mcg SubQ day 1, then 94mcg SubQ day 15, then 125mg SubQ day 29 ☐ Ongoing treatment: 125mcg SubQ every 14 days ☐ 1 year ☐ Other: ___		
Rebif	☐ Prefilled syringes ☐ Rebidose ☐ Initial dose: Titration Pack :8.8 mcg SubQ TIW x 2 weeks, Then 22 mcg SubQ TIW x 2 weeks ☐ Maintenance: 44 mcg SubQ TIW ☐ 22 mcg SubQ TIW ☐ 1 year ☐ Other: ___		
Tecfidera	☐ Initial dose- Starter pack: 120mg BID by mouth for 7 days then 240mg BID by mouth ☐ Maintenance: 240mg BID by mouth ☐ Other: ___		
Zinbryta	☐Inject 150mg SubQ once monthly		

Clinical Data

Primary Diagnosis:	Multiple Sclerosis	ICD-10:		Weight:	pounds	Height:	inches
Allergies:			Failed Therapies:				
Patient Medication List (or attach separately):							

Prescriber Information

Prescriber First Name:		Prescriber Last Name:		Facility Name:
DEA:	State License #:	NPI:	UPIN:	Office Contact E-mail:
Office Address:		City:	State:	Zip Code:
Office Phone:		Office Fax:	Office Contact Name:	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ ***I authorize Advanced Care Scripts to initiate a Prior Authorization on my behalf.*** ***TLC10/18/16***

Prescriber Signature: **Date:**

Prescriber must write "Brand Medically Necessary" in own handwriting to prevent substitution