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 Multiple Sclerosis

MS Severity:
- ❑ Relapsing / Remitting
- ❑ Primary Progressive
- ❑ Secondary Progressive

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 — Quantity: ____
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

___ Maintenance: Inject 0.25mg (1ml) subcutaneously every other day — Quantity: ____ Refills __
___ Other: _____

Dalfampridine 10mg ER *(generic Ampyra)*
___ Take one tablet twice daily every 12 hours — Quantity: ____ Refills __
___ Other: _____

Dimethyl Fumarate *(generic Tecfidera)*
___ Load: Take 120mg by mouth twice daily for 7 days — Quantity: ____
___ Maintenance: Take 240mg by mouth twice daily — Quantity: ____ Refills __

Glatiramer Acetate Injection *(generic Copaxone)*
___ Inject 20mg subcutaneously every day — Quantity: 1 kit Refills __
___ Inject 40mg subcutaneously three times a week — Quantity: 1 kit Refills __
___ addition of **WhisperJECT Autoinjector**

Kesimpta
___ Load: Inject 20mg subcutaneously at weeks 0,1,2 — Quantity: 3
___ Maintenance: Inject 20mg subcutaneously monthly starting at week 4 — Quantity: ____ Refills __

Rebif
___ Titration: — Quantity: ____
__ 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

___ Maintenance:
__ 22 mcg (0.5ml) subcutaneously three times weekly starting at week 5 — Quantity: 1 kit Refills __
or
__ 44 mcg subcutaneously three times weekly starting week 5
__ Other: _____

Physician Prescription Orders:
Physician Name: _____ NPI:_____ Phone: _____ Fax: _____
Address: _____ Date: _____ Nurse: _____
Physician Signature: _____