



(Christus Santa Rosa Hospital, Tower # 1)

Faxed prescriptions will only be accepted from a prescribing practitioner.  
Patients must bring an original prescription to the pharmacy.

# MS Prescription Referral Form

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312  
www.GalaxySpecialtyPharmacy.com

Date Medication Needed: \_\_\_\_\_ Ship To:  Patient's Home  Prescriber's Office  Pick-up \_\_\_\_\_ Injection training by pharmacy?

**1: Patient Information**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. kg.  
 Soc. Sec. #: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_ Known Allergies: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Alternate Caregiver Name: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_

**Insurance Information:** Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

**2: Prescriber Information**

Provider Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Key Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**3: Diagnosis/Clinical Information** | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis: CM G35 Multiple Sclerosis Other: \_\_\_\_\_  
 Has the patient been previously treated for this condition? Yes No  
 Prior failed medication (medication and duration of treatment/reason for d/c): \_\_\_\_\_  
 Patient currently on therapy? Yes No Medication(s): \_\_\_\_\_  
 Will patient be stopping above medication before starting new therapy?  
 Yes No Discontinuation Date: \_\_\_\_\_  
 Is prescriber a Neurologist? If no, please include neurology consult if available.  
 Diagnosis: \_\_\_\_\_ Other: \_\_\_\_\_

Number of relapses in past year: \_\_\_\_\_  
 Last MRI date: \_\_\_\_\_ Any MRI changes? Yes No  
 Injection training completed by:  
 Novantrone:  
 Is patient's LVEF <50%? Yes No  
 What is lifetime (cumulative) Novantrone dose (mg/m2)? \_\_\_\_\_  
 Copy of last CBC with differential: \_\_\_\_\_  
 Is patient pregnant, nursing or planning pregnancy? Yes No N/A  
 Serum Creatine \_\_\_\_\_ Creatinine Clearance \_\_\_\_\_

**4: Prescription Information**

Medication	Dose/Strength	Sig	Qty.	Refills
Avonex®	30mcg Prefilled Syringe #4 30mcg Pen #4	Inject 30mcg IM once weekly	4 week supply	
Betaseron®	0.3mg vial	<b>Dose Titration:</b> • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD <b>Maintenance Dose:</b> 0.25mg /1ml subcutaneously QOD <b>Other:</b>	4 week supply	
Copaxone®	20mg Prefiled Syringe	20mg SQ QD	4 week supply	
Extavia®	0.3mg vial	<b>Maintenance Dose:</b> 0.25mg /1ml subcutaneously QOD <b>Dose Titration:</b> • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD <b>Other:</b>	4 week supply	
Gilenya®	0.5mg capsule	Take 0.5mg po QD	4 week supply	
Rebif® Rebif Redidose®	Titration Pack (8.8mcg/22mcg) 22mcg Prefilled Syringe 44mcg Prefilled Syringe	Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) <b>Maintenance:</b> Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) <b>Maintenance:</b> Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) <b>Other:</b>	4 week supply	

**Patient Support Programs:** Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Prescriber Signature: Prescriber, please sign and date below

Dispense as written \_\_\_\_\_ Date \_\_\_\_\_ Substitution Permissible \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do 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. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: \_\_\_\_\_