



# Patient Referral/ Medication Request Multiple Sclerosis

**Aetna Specialty Pharmacy®**  
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Orlando, FL 32809  
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**FAX:** 1-866-329-2779 (1-866-FAX-ASRX)  
www.AetnaSpecialtyPharmacy.com

**Today's Date:** \_\_\_\_\_

**Anticipated Start Date:** \_\_\_\_\_

**PATIENT INFORMATION**

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office		Email Address:	

**INSURANCE INFORMATION**

<b>Primary Insurance:</b>		<b>Pharmacy Benefit Manager (PBM):</b>	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide #:	
<b>Secondary Insurance:</b>			
Policy #:	Group #:	Insured:	Phone:

**PHYSICIAN INFORMATION**

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:		Email Address:		Phone:	

**DIAGNOSIS:**

<b>Primary:</b>	ICD 9:	<b>Secondary:</b>	ICD 9:
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**PRESCRIPTION** (Please select from below and provide approximate days supply.)

<input type="checkbox"/> <b>AVONEX</b> # of Refills _____ <input type="checkbox"/> 30MCG prefilled syringe # of boxes (4 PFS) _____ <input type="checkbox"/> 30MCG vial # of boxes (4 vials) _____ <input type="checkbox"/> Supplies: Needles 25g 1inch <b>Directions:</b> <input type="checkbox"/> 30MCG IM Weekly <input type="checkbox"/> Other: _____ <input type="checkbox"/> <b>BETASERON</b> # of Refills _____ <input type="checkbox"/> <b>EXTAVIA</b> # of Refills _____ <input type="checkbox"/> 0.3MG Kit 14/Box # of boxes _____ <b>Directions:</b> <input type="checkbox"/> Inject 0.25 mg (1ml). SQ QOD <b>Directions (Initial Titration):</b> <input type="checkbox"/> Inject 0.0625 mg (0.25 ml) SQ QOD for Weeks 1 and 2 <input type="checkbox"/> Inject 0.125 mg (0.5 ml) SQ QOD for Weeks 3 and 4 <input type="checkbox"/> Inject 0.1875 mg (0.75 ml) SQ QOD for Weeks 5 and 6 <input type="checkbox"/> Inject 0.25 mg (1ml) SQ QOD Week 7 and thereafter <input type="checkbox"/> Other: _____ <input type="checkbox"/> <b>COPAXONE</b> # of Refills _____ <input type="checkbox"/> 20 mg PFS # of boxes (30 PFS) _____ <b>Directions:</b> <input type="checkbox"/> Inject 20 mg SQ daily <input type="checkbox"/> Other: _____ <input type="checkbox"/> <b>REBIF</b> # of Refills _____ <input type="checkbox"/> 22 MCG # of boxes (12 PFS) _____ <input type="checkbox"/> 44 MCG # of boxes (12 PFS) _____ <b>Directions SQ:</b> <input type="checkbox"/> Inject three times a week <input type="checkbox"/> <b>REBIF Titration Kit</b> <b>Directions SQ: (Initial Titration):</b> <input type="checkbox"/> Inject 8.8 mcg SQ TIW x Weeks 1 and 2 <input type="checkbox"/> Inject 22 mcg SQ TIW x Weeks 3 and 4 <input type="checkbox"/> Inject 44 mcg SQ TIW thereafter <input type="checkbox"/> Other: _____	<input type="checkbox"/> <b>AMPYRA</b> # of Refills _____ <input type="checkbox"/> 10mg # of doses _____ <b>Directions:</b> <input type="checkbox"/> 1 tab po q 12hrs <input type="checkbox"/> Other: _____ <input type="checkbox"/> <b>BOTOX</b> # of Refills _____ <input type="checkbox"/> 100 Units vial # of vials _____ <input type="checkbox"/> 200 Units vial # of vials _____ <b>Directions:</b> <input type="checkbox"/> To be Injected by MD <input type="checkbox"/> <b>DYSPORT</b> # of Refills _____ <input type="checkbox"/> 500 Units vial # of vials _____ <b>Directions:</b> <input type="checkbox"/> To be Injected by MD <input type="checkbox"/> <b>MYOBLOC</b> # of Refills _____ <input type="checkbox"/> 2500 U Vials # of vials _____ <input type="checkbox"/> 5000 U Vials # of vials _____ <input type="checkbox"/> 10000 U Vials # of vials _____ <b>Directions:</b> <input type="checkbox"/> To be injected by MD <input type="checkbox"/> <b>Other Drug:</b> _____ <b>Strength</b> _____ Frequency: _____ Route: _____ # of Refills _____ Quantity: _____  <p><b>TYSABRI: THIS IS FOR INFORMATIONAL PURPOSES ONLY. TYSABRI IS AVAILABLE ONLY UNDER A SPECIAL RESTRICTED DISTRIBUTION PROGRAM CALLED CD TOUCH. PLEASE CONTACT THE TOUCH PRESCRIBING PROGRAM AT 1-800-456-2255.</b></p>
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**SUPPLIES**

If medication is shipping to the patient's home, all appropriate supplies necessary to administer the medication will be included with the order.

**Prescriber's Signature Required by Law:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space. Incomplete information may result in therapy delay. Please complete all fields.