☐ Home Infusion
☐ Alternate Site of Care

vitalcare of SOUTH DALLAS

MULTIPLE SCLEROSIS REFERRAL FORM

REP
NPI #: 1871219683 **TEL:** 945-212-3707 **FAX:** 866-790-3580

Patient Name _____ SSN (last 4):_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____
Ship to Patient at ☐ Home ☐ Physician Office Primary Language ☐ English ☐ Spanish ☐ Other_____
Allergies _____ ☐ PMH (attached) ☐ Current Medications (attached)

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER NAME AND NPI#

_____ #_____

Insured's Name _____ Relation to Patient _____
Insured's Phone Number _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Policy/Group# _____ Bin# _____ Pcn# _____

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

ICD-10 Code ☐ **G35** Multiple Sclerosis OR ☐ Other_____ ☐ Labs attached
☐ Relapse Remitting ☐ Primary Progressive ☐ Secondary Progressive
Patient currently on therapy? ☐ Yes ☐ No MRI consistent with a MS Diagnosis? ☐ Yes ☐ No Patient functionally ambulatory? ☐ Yes ☐ No
Comments_____

PRESCRIPTION

☐ **OCREVUS** (ocrelizumab) **300mg/10ml vial** ☐ **Pre-Meds**
☐ **Loading Dose**: 300mg IV over 3.5 hours on Day 1 followed by 300mg IV 2 weeks later QTY: 2 Vials Refills: 0
☐ **Maintenance Dose at 6 months** *(beginning 6 months after first 300mg dose)*
☐ **in AIC** ☐ **at home**
600mg IV over 3.5 hours once every 6 months QTY: 2 vials Refills: _____

☐ **AUBAGIO** (teriflunomide)
☐ 7mg: 1 tablet PO QD w/ or w/o food QTY: _____ Refills: _____
☐ 14mg: 1 tablet PO QD w/ or w/o food QTY: _____ Refills: _____

☐ **COPAXONE** (glatiramer acetate)
☐ **GLATOPA** (glatiramer acetate) ☐ **GLATIRAMER ACETATE**
Dose: ☐ 20mg PFS ☐ 40mg PFS
☐ 20mg SQ QD QTY: 30 Refills: _____
☐ 40mg SQ TIW QTY: 12 Refills: _____
☐ Other _____ QTY: _____ Refills: _____

☐ **AMPRYRA** (dalfampridine) 10mg extended release tablet
☐ Dalfampridine ER 10mg extended release tablet
SIG: ____ mg PO BID QTY: _____ Refills: _____

☐ **AVONEX** (interferon beta-1a) 30mcg Dispense: ☐ Pen ☐ PFS
☐ 30mcg IM QW
☐ Other _____ QTY: 1 pack = 4 week supply Refills: _____

☐ **BETASERON** (interferon beta-1b) 0.3mg vial
☐ **EXTAVIA** vials (interferon beta-1b) 0.3mg vial
Starting Dose
☐ Inject 0.0625mg (0.25ml) SQ QOD for weeks 1 & 2 QTY: 1 pack Refills: 0
☐ 0.125mg (0.5ml) SQ QOD for weeks 3 & 4 QTY: 1 pack Refills: 0
☐ 0.1875mg (0.75ml) SQ QOD for weeks 5 & 6 QTY: 1 pack Refills: 0
Maintenance Dose:
☐ 0.25mg (1ml) SQ QOD
☐ Other _____
QTY: 1 pack = 4 week supply Refills: _____

☐ **GILENYA** (fingolimod) 0.5mg *(first dose must be taken at the doctor's office)*
SIG: >40kg: 1 capsule PO QD QTY: _____ Refills: _____

☐ **KESIMPTA** (ofatumumab)
☐ Starter: 20mg SIG: 20mg SQ QW for 3 doses QTY: 3 Refills: 0
☐ Maintenance: 20mg SIG: 10mg SQ QM starting week 4 QTY: _____ Refills: _____

☐ **MAYZENT** (siponimod)
☐ Starter pack Use as directed per package instructions QTY: 1
☐ 2mg SIG: Take one tablet daily QTY: 3 Refills: _____

☐ **PLEGRIDY** (peginterferon beta-1a)
☐ Starter Pack QTY: 3
SIG: SQ or IM 63mcg day 1, 94mcg day 15, 125mcg day 29, then maintenance
☐ Maintenance: 125mcg SIG: 125mcg IM or SQ every 14 days QTY: 2 Refills: _____

REBIF (interferon beta-1a)
☐ **Rebif 22mcg** Prescribed Dose
☐ Rebif Titration Pack
SIG: 4.4mcg (0.1ml) SQ TIW (at least 48hrs apart) weeks 1 & 2.
Then 11mcg (0.25ml) TIW weeks 3 & 4 QTY: 1 pack Refills: 0
☐ Rebif (interferon beta-1a) 22mcg/0.5ml Dispense: ☐ Pen ☐ PFS
SIG: 22mcg (0.5ml) SQ TIW (at least 48hrs apart)
QTY: 1 pack = 4 week supply Refills: _____
☐ **Rebif 44mcg** Prescribed Dose
☐ Rebif Titration Pack
SIG: 8.8mcg SQ TIW (at least 48hrs apart) weeks 1 & 2.
Then 22mcg TIW weeks 3 & 4 QTY: 1 pack Refills: 0
☐ Rebif (interferon beta-1a) 44mcg/0.5ml Dispense: ☐ Pen ☐ PFS
SIG: 44mcg (0.5ml) SQ TIW (at least 48hrs apart) starting week 5 and thereafter
QTY: 1 pack = 4 week supply Refills: _____

☐ **TECFIDERA** (dimethyl fumarate) delayed-release capsules
☐ Starting: 120mg BID for 7 days, then 240mg BID for 23 days QTY: _____ Refills: _____
☐ Maintenance: 240mg BID QTY: _____ Refills: _____

☐ **ZEPOSIA** (ohzanimod)
☐ Starter pack SIG: Use as directed per package instruction QTY: 7 Refills: 0
☐ Maintenance: 0.92mg capsule SIG: Take 1 capsule daily QTY: 30 Refills: ____

☐ **OTHER** _____ SIG: _____ QTY: ____ Refills: ____

DWO - NURSING ORDERS TO FOLLOW

By signing this form and utilizing our services, you are authorizing VitalCare of South Dallas, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____
Prescriber's Email_____ **Prescriber's Fax** _____

Please visit **VITALCARE.COM/LOCATIONS/VITAL-CARE-OF-SOUTH-DALLAS/** for more information