SAGE SPECIALTY PHARMACY

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice.

Sage Specialty Pharmacy Multiple Sclerosis Referral Form

WWW.SAGE-SPECIALTYPHARMACY.COM

Patient Information: Please provide a copy of the patient's insurance card or information				
Patient Name:	DOB:	Gender:	Ht:	Wt:
Address:	City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's Name:		ID#:	Group#:

Allergies: □NKDA □ List Allergies:

Referral Expectations

Injection Training:	Manufacturer Care Kit:	Manufacturer Program Enrollment:
□ Please complete by pharmacy staff	□ Pharmacy to provide to patient	□ Complete at pharmacy
□ Completed by MD office	□ Provided by MD office	□ Completed by MD office
□ Completed by home nurse/mfg program	□ Please do not provide	□ Please do not enroll

Clinical Information: please provide recent clinical notes, labs, and tests to expedite the prior authorization process

ICD-10 and Diagnosis:_____
Number of relapses in past year: ____
Last MRI Date:_____ Serum Creatinine: _____
Pregnant of Planning Pregnancy: □ Yes □ No

Prior Treatment (name and date/length of treatment):_____
_____
Current Treatment (name and start date):_____
_____

Prescription Information

Medication	Strength	Sig	Quantity	Refills
□ Avonex	□ 30mcg Prefilled Syringe □ 30mcg Pen □ 30mcg Vial	□ Initial: Week 1: Inject 7.5mcg IM. Week 2: Inject 15mcg IM. Week 3: Inject 22.5mcg IM. Week 4: inject 30 mcg IM. □ Maintenance: Inject 30mcg IM once weekly	□ 1 Box	
□ Betaseron	□ 0.3mg Vial	□ Initial: Weeks 1-2: Inject 0.0625mg (0.25mL) every other day. Weeks 3-4: Inject 0.125mg (0.5mL) every other day. Week 5-6: Inject 0.1875mg (0.75mL) every other day. □ Maintenance: Inject 0.25mg (1mL) SC every other day	□ 1 Box	
□ Copaxone	□ 20mg Prefilled Syringe □ 40mg Prefilled Syringe	□ Inject 20mg SC once daily □ Inject 40mg SC 3 times per week (at least 48 hours apart)	□ 1 Box	
□ Dalfampridine (generic Ampyra)	□ 10mg ER Tablet	□ Take 1 tablet by mouth every 12 hours	□ 60 Tabs	
□ Dimethyl Fumarate (Generic Tecfidera)	□ 120mg Capsule □ 240mg Capsule	□ Take 1 capsule by mouth twice daily for 7 days □ Take 1 capsule by mouth twice daily	□ 14 Caps □ 60 Caps	□ 0 □
□ Glatopa	□ 20mg Prefilled Syringe □ 40mg Prefilled Syringe	□ Inject 20mg SC once daily □ Inject 40mg SC 3 times per week (at least 48 hours apart)	□ 1 Box	
□ Extavia	□ 0.3mg Vial	□ Initial: Weeks 1-2: Inject 0.0625mg (0.25mL) every other day. Weeks 3-4: Inject 0.125mg (0.5mL) every other day. Week 5-6: Inject 0.1875mg (0.75mL) every other day. □ Maintenance: Inject 0.25mg (1mL) SC every other day	□ 1 Box	
□ Gilenya	□ 0.5mg Capsule	□ Take 1 capsule by mouth once daily	□ 30 Caps	
□ Kesimpta	□ 20mg Pen	□ Inject 20mg SC once weekly □ Inject 20mg SC once monthly	□ 4 Pens □ 1 Pen	□ 0 □
□ Plegridy	□ Starter Kit (Pens) □ Starter Kit (Prefilled Syringe) □ 125mcg Pen □ 125mcg Prefilled Syringe	□ Initial: Inject 63mcg SC on day 1, then 94mcg on day 15 □ Inject 125 mcg every 14 days	□ 1 Box	

I authorize Sage Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. 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.

□ Rebif □ Rebif Rebidose	□ Titration Pack (8.8mcg/22mcg) □ 22mcg/0.5mL □ 44mcg/0.5mL	Initial: □ Inject 8.8mcg SC 3 times weekly for 2 weeks, then 22mcg 3 times weekly for 2 weeks. □ Inject 4.4mcg SC 3 times weekly for 2 weeks, then 11mcg 3 times weekly for 2 weeks Maintenance: □ Inject 44mcg SC 3 times weekly □ Inject 22mcg SC 3 times weekly	□ 1 Box	
□ Zeposia	□ Starter Kit (0.23mg/0.46mg/0.92mg) □ 0.92mg Capsules	□ Take 0.23mg by mouth daily for 4 days, then 0.46mg daily for 3 days, then 0.92mg daily thereafter □ Take 1 capsule by mouth every day	□ 1 Kit □ 30 Caps	□ 0 □
□	□	□	□	

Prescriber Information				
Name:	Phone:		Office Contact Name:	
Address:		City:	State:	Zip:
NPI:	DEA:	Fax and/or Email:		
Prescriber Signature:		Date:		□ DO NOT SUBSTITUTE

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