VERBAL ORDER FORM
NEUROLOGY

PFSP
@pfsprx #pfsprx

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Ph 844-527-9486 | Fx 866-285-7628
NPI# 1669881777 NABP# 3148839
info@pfsprx.com PFSPrx.com

Today's Date _____
Date Needed _____

ACHC ACCREDITED

urac ACCREDITED
Specialty Pharmacy
Expires 07/01/2023

urac ACCREDITED
Rare Disease Pharmacy Center of Excellence
Expires 07/01/2023

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office
☐ Nurse / Training
☐ PFSP Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code: ☐ G35 Multiple Sclerosis ☐ G43 Migraine ☐ G70 Myasthenia gravis ☐ Other Diagnosis_____
Type: ☐ Relapsing-remitting ☐ Primary progressive ☐ Secondary progressive ☐ Progressing Relapsing ☐ Other Diagnosis_____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____
Current medications (including OTC) w/ dosage & direction (or fax medication) _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

MIGRAINE THERAPIES

☐ **AIMOVIG** ☐ 70mg/mL SureClick ☐ 140mg/mL SureClick ☐ 70mg/mL autoinjector (2-ct.)
SIG: Inject ☐ 70mg **OR** ☐ 140mg SQ once monthly QTY: ____ Refills: ____

☐ **AJOVY** 225mg/1.5mL PFS
☐ SIG: Inject 225mg SQ once monthly QTY: 1 PFS Refills: _____
☐ SIG: Inject 675mg SQ once every 3 months QTY: 3 PFS Refills: _____

☐ **EMGALITY** ☐ 100mg/mL PFS (3-ct.) ☐ 120mg/mL PFS ☐ 120mg/mL Pen
☐ Starter SIG: Inject 240mg SQ initially QTY: 2 Refills: 0
☐ Maintenance SIG: Inject 120mg SQ once monthly thereafter
QTY: 1 kit Refills: _____
☐ Cluster period SIG: Inject 300mg SQ at onset of cluster period, then once monthly thereafter QTY: 3 Refills: _____

HIGH-EFFICIENCY THERAPY

☐ **LEMTRADA** 12mg/1.2mL SDV ☐ Enroll in *MS One to One*
☐ Year 1: Infuse 12mg IV daily for 5 consecutive days QTY: 5 vials Refills: 0
☐ Year 2: Infuse 12mg IV daily for 3 consecutive days QTY: 3 vials Refills: 0

☐ **OCREVUS™** 300mg/10mL SDV ☐ Enroll in *OCREVUS CONNECTS*
☐ Starting dose: Infuse 300mg IV on Day 1, then infuse 300mg IV on Day 15
QTY: 2 vials Refills: 0
☐ Maint: Infuse 600mg IV every 6 months thereafter QTY: 2 vials Refills: ____

☐ **TYSABRI®** 300mg/15 ml SDV ☐ Enroll in *Tysabri TOUCH*
SIG:Infuse 300mg IV over 1 hour every 4 weeks QTY: 1 vial Refills: _____

☐ **RITUXAN** ☐ 100mg/10mL vial ☐ 500mg/50mL vial Weight: ____ kg
☐ Starter: Infuse 375mg/m2 IV once wkly for 4 wks QTY: ___ vial(s) Refills: 0
☐ Maint: Infuse 375mg/m2 IV once monthly (for 2 months)
QTY: ____ vial(s) Refills: 1
☐ Other SIG:_____ QTY: _____vial(s) Refills: _____

SEIZURE THERAPY

☐ **ELEPSIA XR TABLETS** ☐ 1000mg ☐ 1500mg
SIG: 1 PO QD QTY: 30 tablets Refills: _____

☐ **COPAXONE** ☐ **GLATOPA** ☐ **GLATIRAMER ACETATE**
☐ 20mg PFS (30-ct) ☐ 40mg PFS (12-ct)
☐ SIG: Inject 20mg SQ daily QTY: 30 Refills: _____
☐ SIG: Inject 40mg SQ TIW QTY: 12 Refills: _____
☐ DAW-1: Brand medically necessary ☐ Enroll in *Shared Solutions*

ORAL THERAPY

☐ **AUBAGIO** ☐ 7mg tablet ☐ 14mg tablet ☐ Enroll in *MS One to One*
SIG: Take one tablet by mouth once daily QTY: _____ Refills: _____

☐ **TECFIDERA** ☐ Starter Pack ☐ 240mg tablet ☐ Enroll in *AboveMS*
☐ Starter SIG: Take 120mg by mouth BID for 7 days, then 240mg by mouth BID
QTY: 1 pack Refills: 0
☐ Maintenance SIG: Take 240mg by mouth BID QTY: _____ Refills: _____

☐ **GILENYA™** 0.5mg capsule ☐ Enroll in *GILENYA Go Program*
SIG: Take one capsule by mouth daily QTY: ☐ 30 ☐ 90 Refills: _____

☐ **MAYZENT®** ☐ Starter Pack ☐ 0.25mg tablet ☐ 2mg tablet
SIG:_____ QTY: _____ Refills: _____
☐ Enroll in *Alongside MS*

☐ **MAVENCLAD THERAPY PACK®** 10mg tablets Weight: ____ kg
☐ Year 1: SIG: _____ QTY: _____ Refills: _____
☐ Year 2: SIG: _____ QTY: _____ Refills: _____
☐ Enroll in *MS Lifelines*

☐ **VUMERITY™** 231mg capsules QTY: 106 capsules (30-day supply) Refills: _____
SIG: Take 1 capsule by mouth 2x daily for 7 days, then two capsules 2x daily

INTERFERON THERAPY

☐ **AVONEX®** 30mcg/0.5mL ☐ Pen ☐ PFS ☐ Enroll in *MS ActiveSource*
SIG: Inject 30mcg IM once weekly QTY: 4 injections Refills: _____

☐ **REBIF®** ☐ **REBIDOSE®** ☐ Enroll in *MS Lifelines*
☐ 22mcg PFS ☐ 44mcg PFS ☐ Titration Pack 8.8mcg/22mcg
SIG:_____ QTY: 12-count Refills: _____

☐ **BETASERON®** 0.3mg vial with diluent syringe (14-ct) ☐ Enroll in *Beta Plus MS*

☐ **EXTAVIA** 0.3mg vial with diluent syringe (15-ct) ☐ Enroll in *Extavia Program*
☐ Starter SIG: _____ QTY: _____ Refills: ____
☐ Maintenance SIG: 0.25 mg (1ml) SQ every other day
☐ Other_____ QTY: 30 Day Supply Refills: _____

☐ **PLEGRIDY STARTER PACK** 63mcg/94mcg ☐ Pens ☐ PFS
☐ Starter SIG: Inject 63mcg SQ on Day 1, then inject 94mcg SQ on Day 15
QTY: 1 kit Refills: 0 ☐ Enroll in AboveMS

☐ **PLEGRIDY** 125mcg ☐ Pens ☐ PFS
☐ Maintenance SIG: Inject 125mcg SQ every two weeks beginning on Day 29
QTY: 2 Refills: _____ ☐ Enroll in *AboveMS*

SUPPORTIVE THERAPY

☐ **AMPYRA®** 10mg ER 12-hour tablet SIG: Take one tablet by mouth twice daily QTY: ☐ 60 ☐ 120 Refills: _____ ☐ Enroll in *Ampyra Patient Support Services*
☐ **ACTHAR GEL®** 80units/mL (5mL MDV) SIG: _____ QTY: _____ Refills: _____
☐ **RELAFEN DS** 1000mg ☐ SIG: 1 PO QD QTY: 30 tablets Refills: _____ ☐ SIG: 1 PO BID QTY: 60 tablets Refills: _____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **PFSP** at **866-285-7628**
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