

Community Consultant Contact: _____

Fax referral to: 844-814-1944 Phone: 844-814-1943

Email referral form to: connect@realospecialtycare.com

For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ Male Female SS#: _____ DOB: _____
 Address: _____ City, State, Zip: _____
 Primary Phone: _____ Home Cell Work Alternate Phone: _____ Home Cell Work
 Email: _____ Height: _____ Weight: _____
 Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____
 Address: _____ City, State, Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____

SHIPPING INFORMATION

Ship To: Patient Physician/Clinic Realo Location: _____
 Date Shipment Needed By: _____ Alternate Location: _____
 Shipping Address: _____ City, State, Zip: _____

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Primary ICD-9 Code: 340 Secondary ICD-9 Code: _____ Date of first demyelinating event: _____
 Type: Clinically isolated syndrome Relapsing-remitting Secondary-progressive Primary-progressive Progressive-relapsing
 BMD/T-score: _____ Date: _____ Is patient new to therapy? yes no
 Please provide clinical rationale for prescribing this agent (if not preferred formulary agent): _____
 Prior therapies: _____
 Reason for discontinuation: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Betaseron®	<input type="checkbox"/> 0.3 mg vial	<input type="checkbox"/> Dose Titration: Week 1-2: Inject 0.0625 mg (0.25 mL) subq every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subq every other day; Week 5-6: Inject 0.1875 mg (0.75 mL) subq every other day; Week 7-8: Inject 0.25 mg (1 mL) subq every other day. <input type="checkbox"/> Maintenance Dose: Inject 0.25 mg (1 mL) subq every other day	<input type="checkbox"/> 4 week supply	
<input type="checkbox"/> Copaxone®		<input type="checkbox"/> Inject 20 mg subq once daily	<input type="checkbox"/> 30 mL	
<input type="checkbox"/> Glatiramer Acetate		<input type="checkbox"/> Inject 40 mg subq 3 times per week administered at least 48 hours apart	<input type="checkbox"/> 12 mL	
<input type="checkbox"/> Glatopa™				
<input type="checkbox"/> Dalfampridine	<input type="checkbox"/> 10 mg	<input type="checkbox"/> Take 10 mg by mouth twice a day, approximately 12 hours apart	<input type="checkbox"/> 60	
<input type="checkbox"/> Dimethyl Fumarate	<input type="checkbox"/> 120 mg <input type="checkbox"/> 240 mg	<input type="checkbox"/> Initial: take one capsule by mouth twice daily for 7 days <input type="checkbox"/> Maintenance: take one capsule by mouth twice daily	<input type="checkbox"/> 14 <input type="checkbox"/> 60	
<input type="checkbox"/> Gilenya®	<input type="checkbox"/> 0.5 mg	<input type="checkbox"/> Take one capsule by mouth once daily <input type="checkbox"/> Other:	<input type="checkbox"/> 1 box (28 capsules) <input type="checkbox"/> 1 bottle (30 capsules)	
<input type="checkbox"/> Kesimpta	<input type="checkbox"/> 20 mg Pen	<input type="checkbox"/> Initial: Inject 20 mg weekly for three weeks <input type="checkbox"/> Maintenance: Inject 20mg once monthly starting on week 4	<input type="checkbox"/> 3 <input type="checkbox"/> 1	
<input type="checkbox"/> Ocrevus™ In Office Administration	<input type="checkbox"/> 300 mg/10 mL	<input type="checkbox"/> Infuse 300 mg intravenously over no less than 2.5 hours on day and day 15 <input type="checkbox"/> Infuse 600 mg intravenously over no less than 3.5 hours 6 months after the day 1 infusion and every 6 months thereafter	<input type="checkbox"/> 2 <input type="checkbox"/> 2	
<input type="checkbox"/> Rebif®	<input type="checkbox"/> Titration Pack 4.4mcg/22 mcg <input type="checkbox"/> 22 mcg PFS <input type="checkbox"/> Titration Pack 8.8mcg/44 mcg <input type="checkbox"/> 44 mcg PFS	<input type="checkbox"/> Dose Titration: Week 1-2: Inject 4.4 mcg (0.1 mL) subcut three times per week; Week 3-4: Inject 11 mcg (0.25 mL) subcut three times per week. <input type="checkbox"/> Week 5 and thereafter: Inject 22 mcg subcut three times per week <input type="checkbox"/> Dose Titration: Week 1-2: Inject 8.8 mcg (0.2 mL) subcut three times per week; Week 3-4: Inject 22 mcg (0.5 mL) subcut three times per week. <input type="checkbox"/> Week 5 and thereafter: Inject 44 mcg subcut three times per week	<input type="checkbox"/> 4 week supply <input type="checkbox"/> 4 week supply	

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature _____ Date _____ Substitution Permissible - Signature _____ Date _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.