UNIVERSAL
• SPECIALTY PHARMACY •

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www.rxuniversal.com

Multiple Sclerosis Referral Form

☐ **Urgent/Stat** ☐ **Standard**

Prescriber

Prescriber Information

Prescriber Name:			☐MD ☐PA ☐NP	
NPI:	DEA:		Office Contact:	
Address:				
City:	State:	Zip:	Phone #:	Fax #:

Patient

Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards

First Name:		MI:	Last Name:	
DOB:	Sex: ☐M ☐F	Last 4 Digits SSN :	Interpreter: ☐Y ☐N Specify:	
Address:				
City:	State:	Zip:	Primary #:	Alternate #:
Emergency Contact:	Phone #:		Contact Preference: ☐AM ☐Noon ☐PM	

Clinical

Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents

Primary ICD10:	Secondary ICD10:	Diagnosis Date: / /
Weight: ☐lb/ ☐kg	Height: ☐in/ ☐cm	Allergies:
Current Medications:		
Prior Therapies:		
Continuity of Care: / /		

Prescription

Prescription Information

Dose Start Date: / / ☐New Prescription ☐Refill Prescription ☐New to Therapy ☐Restarting Therapy

Deliver to: ☐Patient's Home ☐Prescriber's Office ☐Other

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Ampyra®	☐10 mg Tablet			
☐ Aubagio®	☐7 mg Tablet ☐14 mg Tablet			
☐ Avonex®	☐30 mcg Syringe ☐30 mcg Pen			
☐ Betaseron®	☐0.3 mg Vial & Diluent			
☐ Copaxone®	☐20 mg Syringe ☐40 mg Syringe			
☐ Extavia®	☐0.3 mg Vial & Diluent			
☐ Gilenya®	☐0.5 mg Capsule			
☐ Glatopa®	☐20 mg Syringe			
☐ Mitoxantrone®	☐20 mg/10 mL Vial ☐25 mg/12.5 mL Vial ☐30 mg/12.5 mL Vial			
☐ Ocrevus®	☐300 mg/10 mL single dose vial ☐Nursing services by BriovaRx Infusion Services requested			
☐ Plegridy®	☐Prefilled Syringe Starter Pack ☐125 mcg/05 mL Pen ☐40 mg Syringe ☐Pen Starter Pack			
☐ Rebif®	☐Titration Pack ☐Rebidose® Auto-Injector Titration ☐22 mcg Syringe ☐Rebidose® Auto-Injector 22 mcg ☐44 mcg Syringe ☐Rebidose® Auto-Injector 44 mcg			
☐ Tecfidera®	☐120 mg Capsule ☐240 mg Capsule ☐30- Day Starter Pack			

☐ Other:

☐ Dispense ancillary supplies, syringes and medical equipment necessary to administer medication.

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training ☐ Universal to coordinate injection training

By signing this form and utilizing our services, you are authorizing Universal Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Sign

Prescriber Signature and Date (Required to validate prescription)

Physician Signature:	Date: / /