Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

Padek Healthcare Multiple Sclerosis Referral Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

ICD-10 Diagnosis Code ☐ G35 Multiple Sclerosis **OR** Other _____ Weight _____ Allergies _____

Patient currently on therapy ☐ Yes ☐ No Date of next blood work _____ Comments _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AVONEX ADMINISTRATION PACK 30mcg PreFilled

SIG ☐ Inject 30mcg IM once weekly
☐ Other _____
QTY # _____ Weeks *(1 pack = 4 week supply)* Refills x _____

BETASERON 0.3mg Vials

SIG ☐ Inject _____ SC every other day
☐ Other _____
QTY # _____ Weeks *(1 box = 4 week supply)* Refills x _____

COPAXONE

SIG ☐ Inject 20mg (2ml) SC once daily
SIG ☐ Inject 40mg (1ml) SC three times a week
☐ Other _____
QTY # _____ Syringes Refills x _____

REBIF TITRATION PACK 12 syringes

SIG ☐ 8.8mcg SQ TIW - weeks 1 & 2 ☐ 22mcg SQ TIW - weeks 3 & 4
Maintenance Dose following week 3 & 4

REBIF 22mcg/0.5ml

SIG ☐ 22mg (0.5ml) SQ TIW (48hrs apart)

REBIF 44mcg/0.5ml (maintenance)

SIG ☐ starting week 5: 44mcg (0.5ml) SQ TIW (48hrs apart)
QTY # _____ Boxes *(1 box = 4 week supply)* Refills x _____

OTHER _____

SIG _____ QTY _____ Refills x _____

By signing this form and utilizing our services, you are authorizing Padek Healthcare and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

PLEASE FAX COMPLETED REFERRAL FORM TO PADEK HEALTHCARE AT 301-277-7127