

# Multiple Sclerosis Referral Form

Fax completed form to: 833-908-1122



PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			

PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:	NPI#:	
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

MS CLINICAL DETAILS	
<b>Type of MS:</b>	Primary progressive multiple sclerosis (PPMS) ---OR--- Relapsing multiple sclerosis (RMS)
<b>Ambulation status:</b>	Able to ambulate more than 5 meters    Able to ambulate without aid or rest for at least 100 meters
<b>Relapse details:</b>	Two or more relapses within the previous two years    One relapse within the previous year

PLEASE ATTACH	
Patient demographics & front/back copy of all insurance cards (prescription & medical)	Quantitative serum Immunoglobulin lab results ( <i>Ocrevus only</i> )
Recent office visit notes, history & physical, lab & pertinent procedure results	Vaccine status (any vaccination) and documentation of any recent vaccinations
Current medication list & list of prior medications tried and failed (with dates)	HBV lab results within last 12 months ( <i>Ocrevus only</i> )
Line access documentation/verification if applicable	Letter of medical necessity if drug dosing or indication is outside of FDA guideline

NURSING & LAB ORDERS	
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.	
<b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed    Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line	
<b>Lab Orders:</b>	<b>Lab Date &amp; Frequency:</b>

PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____ mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other _____
<b>Pre-Medications:</b>	Acetaminophen _____ mg PO _____ minutes prior to infusion	Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion	
(Check all that apply)	Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion	Other _____	

**Supply Orders:** All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose?	Yes    No    If No, when was last dose given? _____ When is patient due for next dose? _____	
OCREVUS	<b>Induction:</b> 300mg IV infusion via gravity ---OR--- pump over at least 2.5 hours followed 2 weeks later by 300mg IV infusion over at least 2.5 hours	NONE
	<b>Maintenance:</b> 600mg IV infusion via gravity ---OR--- pump over 3.5 hours every 6 months (if no prior serious infusion reactions, may administer over at least 2 hours) <b>Post Infusion:</b> Sodium Chloride 0.9% 100ml administer IV to keep line open (KVO) for one hour following infusion (Per PI, Corticosteroid and antihistamine required for pre-medication, refer to section above)	_____
TYSABRI	300mg IV infusion via gravity ---OR--- pump over one hour every 4 weeks <b>Post Infusion:</b> Sodium Chloride 0.9% 100ml administer IV to keep line open (KVO) for one hour following infusion	NONE
IG	<b>For Immunoglobulin therapy please refer to Immunoglobulin Form</b>	
LEMTRADA	<b>For Lemtrada therapy please refer to Lemtrada Form</b>	
OTHER		

**By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.**

Prescriber's Signature	Print Name	Date	Prescriber's Signature	Print Name	Date
<u>Dispense as Written</u>			<u>Substitution Permitted</u>		