Multiple Sclerosis Referral Form





Fax Completed Form To: **Phone:** 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** Type of MS: Primary progressive multiple sclerosis (PPMS) --- OR--- Relapsing multiple sclerosis (RMS) Ambulation status: Able to ambulate more than 5 meters Able to ambulate without aid or rest for at least 100 meters **Relapse details:** 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 (Ocrevus only) 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 (Ocrevus only) □ Line access documentation/verification if applicable Letter of medical necessity if drug dosing or indication is outside of FDA guideline **NURSING & LAB ORDERS** Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Flush Orders: 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 Lab Orders: Lab Date & Frequency: **PRESCRIPTION ORDERS** □ Solu-cortef 250mg-500mg IV infusion as needed Anaphylaxis Kit: Epinephrine 0.3mg IM as needed □ Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) Diphenhydramine mg IV infusion as needed D NS Hydration 500 ml IV infusion over 30 minutes as needed □ Other Pre-Medications: □ Acetaminophen mg PO minutes prior to infusion □ Solu-Medrol mg IV infusion minutes prior to infusion mg PO ----OR---- IV infusion (Check all that apply) Diphenhydramine 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 **PRESCRIPTION INFORMATION** PRODUCT REFILLS Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose? NONE 🗆 Induction: 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 □ Maintenance: 600mg IV infusion via □ gravity ---OR--- □ pump over 3.5 hours every 6 months (if no prior serious infusion reactions, may administer over □ OCREVUS at least 2 hours) Post Infusion: 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) NONE 300mg IV infusion via gravity --- OR--- pump over one hour every 4 weeks □ TYSABRI Post Infusion: Sodium Chloride 0.9% 100ml administer IV to keep line open (KVO) for one hour following infusion ΠIG For Immunoglobulin therapy please refer to Immunoglobulin Form □ LEMTRADA For Lemtrada therapy please refer to Lemtrada Form □ 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 <u>Dispense as Written</u> Print Name

Date

Prescriber's Signature Substitution Permitted Print Name

Date

ACHC ACCREDITED

