Multiple Sclerosis Referral Form

Fax Completed Form To: **Phone:**

Amerita
YOUR INFUSION ADVOCATE

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)
☐ Recent office visit notes, history & physical, lab & pertinent procedure results
☐ Current medication list & list of prior medications tried and failed (with dates)
☐ Line access documentation/verification if applicable

☐ Quantitative serum Immunoglobulin lab results (*Ocrevus, Briumvi*)
☐ Vaccine status (any vaccination) and documentation of any recent vaccinations
☐ HBV lab results within last 12 months (*Ocrevus, Briumvi*)
☐ Aminotransferases, alkaline phosphatase and bilirubin lab results (*Briumvi*)
☐ 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

Anaphylaxis Kit: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed
☐ Diphenhydramine _____ mg IV infusion as needed
☐ Solu-cortef 250mg-500mg IV infusion as needed
☐ NS Hydration 500 ml IV infusion over 30 minutes as needed
☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion
☐ Solu-Medrol _____mg 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	☐ **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	NONE
	☐ **Maintenance**: 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) **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)	_____
☐ BRIUMVI	☐ **Induction**: 150mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over approx. 4 hours followed 2 weeks later by 450mg IV infusion over approx 1 hour	NONE
	☐ **Maintenance**: 450mg IV infusion over approx 1 hour 24 weeks after first infusion and every 24 weeks thereafter	_____
☐ OCREVUS ZUNOVO (Ocrelizumab and Hyaluronidase)	Ocrelizumab 920 mg/hyaluronidase 23,000 units SC over approximately 10 minutes once every 6 months	_____
☐ TYSABRI	300mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over one hour every 4 weeks **Post Infusion**: Sodium Chloride 0.9% 100ml administer IV to keep line open (KVO) for one hour following infusion	_____
☐ IG	***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 to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

AME_MS Referral Form 8.24

ameritaiv.com
THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

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