

Multiple Sclerosis Order 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)		☐ Quantitative serum Immunoglobulin lab results (<i>Ocrevus</i> , <i>Briumvi</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</i> , <i>Briumvi</i>)	
☐ Line access documentation/verification if applicable		☐ Aminotransferases, alkaline phosphatase and bilirubin lab results (<i>Briumvi</i>)	
		☐ 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: ☐ 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			
Pre-Medications: ☐ 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	☐ 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 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
☐ 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 ☐ 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			

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date



ACHC
ACCREDITED

ACCREDITED
Compounding Pharmacy