# Multiple Sclerosis Referral Form

**Fax completed form to: 833-908-1122**

amerita
specialty infusion services

## 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 only)*
- ☐ Vaccine status (any vaccination) and documentation of any recent vaccinations
- ☐ HBV lab results within last 12 months (*Ocrevus only*)
- ☐ 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 ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

**Pre-Medications:** (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ 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 | 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)<br>**Post Infusion**: Sodium Chloride 0.9% 100ml administer IV to keep line open (KVO) for one hour following infusion<br>(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<br>**Post Infusion**: Sodium Chloride 0.9% 100ml administer IV to keep line open (KVO) for one hour following infusion | NONE<br>_____ |
| ☐ 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, Inc. to serve as your prior authorization designated agent 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 REFER 10-23*



ACHC ACCREDITED
PAB ACCREDITED Compounding Pharmacy