

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 (<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		
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
☐ 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	NONE
☐ 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

Prescriber's Signature

Print Name

Date