Multiple Sclerosis Order Form

Fax completed form to: ___________________

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 and Briumvi only)*
- Vaccine status (any vaccination) and documentation of any recent vaccinations
- HBV lab results within last 12 months *(Ocrevus and Briumvi 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?_________________	
BRIUMVI	**Induction**: 150mg IV infusion via gravity ***---OR---*** pump over at least 4 hours followed 2 weeks later by 450mg IV infusion over at least 1 hour **Maintenance**: 450mg IV infusion via gravity ***---OR---*** pump over 1 hour 24 weeks after the first infusion and every 24 weeks thereafter **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 ________
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, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Signature Substitution Permitted	Print Name	Date

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