

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)			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	
(Check all that apply)		Diphenhydramine _____ mg 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:		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				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)				_____
TYSABRI	300mg IV infusion via gravity ---OR--- pump over one hour every 4 weeks				NONE
	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, 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					

