

Multiple Sclerosis Order Form



Fax completed form to: _____

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		Referral Date:	
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.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
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 (<i>Ocrevus and Briumvi only</i>) Vaccine status (any vaccination) and documentation of any recent vaccinations HBV lab results within last 12 months (<i>Ocrevus and Briumvi only</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? _____		
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 _____