

MULTIPLE SCLEROSIS REFERRAL FORM

Please complete the following and fax with clinical documentation to: 720.870.2414

Referral Process				
1. PATIENT INFORMATION		2. PHYSICIAN INFORMATION		
Name:		Physician's name:		
Address:		License #:		NPI #:
City:	State:	DEA #:		Zip:
Home Phone:		Other Phone:		
Address:		City:		
Email:		State:		Zip:
DOB:		Social Security #:		
Office Contact:		Phone:		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Height:		Weight:
Fax:		Allergies: _____		
3. DIAGNOSIS: G35 Multiple Sclerosis Has the patient been previously treated for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried and failed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of relapses in the past year: _____		Last MRI date: _____ Any Changes? <input type="checkbox"/> Yes <input type="checkbox"/> No SCr: _____ CrCL: _____ TB Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Hepatitis B virus screening: <input type="checkbox"/> Yes <input type="checkbox"/> No Novantrone[®] : Is patients LVEF <50% <input type="checkbox"/> Yes <input type="checkbox"/> No Infuse 12mg/m2 every 3 months What is the lifetime (cumulative) Novantron [®] dose? _____mg/m2 Please provide a copy of last CBC w/ diff.; date _____ If Kesimpta[®] prescribed , provide quantitative serum IG screening <input type="checkbox"/> Is patient pregnant or nursing <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. INSURANCE INFORMATION: Please submit copies of the front and back of primary and secondary insurance cards with this referral.				
5. PRESCRIPTION INFORMATION				
<input type="checkbox"/> Ocrevus [™]	300mg/10ml vial*	<input type="checkbox"/> Initial dosing: Infuse 300 mg IV as directed followed two (2) weeks later by a second 300 mg IV dose <input type="checkbox"/> Subsequent dosing: Infuse 600 mg IV as directed every six (6) months *Each 300 mg dose must be diluted in 250 mls of 0.9% Sodium Chloride for injection	4 week supply	_____ refills
<input type="checkbox"/> Kesimpta [®]	20 mg Prefilled Syringe 20 mg Pen	<input type="checkbox"/> Initial Dosing: 20 mg SC administered at Week 0, 1, and 2 <input type="checkbox"/> Subsequent Dosing: 20 mg SC administered monthly starting at Week 4	4 week supply	_____ refills
<input type="checkbox"/> Tysabri [®]	300mg/15ml vial*	Infuse 300 mg IV over 1 hour every 4 weeks *Each 300 mg must be diluted in 100 mls of 0.9% Sodium Chloride for injection	4 week supply	_____ refills
<input type="checkbox"/> Avonex [®]	30mcg Prefilled Syringe #4 30mcg Pen #4	Inject 30mcg IM once weekly Week 1: 7.5mcg (0.125ml) IM Week 2: 15mcg (0.25ml) IM Week 3: 22.5 mcg (0.375ml) IM Week 4: 30mcg (0.5ml) IM	4 week supply	_____ refills

<input type="checkbox"/> Betaseron® <input type="checkbox"/> Extavia®	0.3mg vial 0.3mg vial	<input type="checkbox"/> Dose Titration: Weeks 1-2: inject 0.0625mg/0.25ml SQ every other day Weeks 3-4: inject 0.125mg/0.50ml SQ every other day Weeks 5-6: inject 0.1875mg/0.75ml SQ every other day Weeks 7+: inject 0.25mg/1ml SQ every other day <input type="checkbox"/> Maintenance: inject 0.25mg/1ml SQ every other day	4 week supply	_____ refills
<input type="checkbox"/> Copaxone®	20mg Prefilled Syringe 40mg Prefilled Syringe	<input type="checkbox"/> 20mg SQ daily <input type="checkbox"/> 40mg SQ 3 times per week	4 week supply	_____ refills
<input type="checkbox"/> Gilenya®	0.5mg capsules 0.25mg capsules	<input type="checkbox"/> 0.5 mg po once-daily in adults and pediatric patients 10 years of age and older weighing more than 40 kg <input type="checkbox"/> 0.25 mg po once daily in pediatric patients 10 years of age and older weighing less than or equal to 40 kg	4 week supply	_____ refills
<input type="checkbox"/> Rebif®	<input type="checkbox"/> 8.8mcg Prefilled Syringe or Autoinjector <input type="checkbox"/> 22mcg Prefilled Syringe or Autoinjector <input type="checkbox"/> 44mcg Prefilled Syringe or Autoinjector	<input type="checkbox"/> Weeks 1-2: inject 8.8mcg SQ three times per week <input type="checkbox"/> Weeks 3-4: inject 22mcg SQ three times per week <input type="checkbox"/> Weeks 5+: (48 hrs apart): inject 44mcg SQ three times per week <input type="checkbox"/> Week 1-2: inject 4.4mcg (0.1ml) SQ three times per week <input type="checkbox"/> Week 3-4: inject 11mcg (0.25ml) SQ three times per week <input type="checkbox"/> Maintenance: inject 22mcg (0.5ml) SQ three times per week	4 week supply 4 week supply	_____ refills _____ refills

Premeds: Methylprednisolone _____ Diphenhydramine _____
Ship to: Prescribers Office Patient's Home | Injection Training completed by: _____

6. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
 Heparin 10 unit/ml Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*
Age 1-5: 12.5mg IV/PO x1 **Age 6-11:** 25mg IV/PO x1 **Age 12+:** 50mg IV/PO x1
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.

If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

Other: _____

Labs: _____

8. Dispense as written Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ Date: _____