

Multiple sclerosis biologic therapies referral form

Infusion Pharmacy Phone:

Fax:

✂ Please detach before submitting to a pharmacy - tear here.

Care specialist Name:

Phone:

Patient information see attached

PEDIATRIC (Younger than 13 years, or less than 45kg in weight)

Page 1 of 2

Patient name:

Gender: M F DOB:

Last 4 of SSN:

Address:

City:

State:

ZIP:

Phone:

Cell:

Emergency contact:

Phone:

Relationship:

Insurance Front and back of insurance cards to follow

Primary Insurance:

Phone:

Policy #:

Group:

Secondary Insurance:

Phone:

Policy #:

Group:

Primary diagnosis ICD-10 code

Diagnosis:

Primary progressive
Isolated Syndrome

Active Secondary Progressive
Relapsing remitting

Medical assessment Height in inches:

Weight **in kg only**:

Date weight (**in kg**) obtained:

Current medications? Yes No If yes, list or attach:

Allergies:

HBV most recent testing date:*

*Attach test results and clinical evaluation notes, as applicable. Include rationale for any tests not performed. Note in orders below if requesting lab draws at infusion nurse visit.

Serum Ig most recent testing date:*

Tried and failed therapies: include supportive clinical documents.

IV Access: PIV CVAD Implantable port

Prescription and orders Medication infused per the drug PI recommended rate and via rate controlled device per therapy

Medication **Dose and directions** (select all that apply)

Ocrevus x1 year	<p>Doses 1 and 2: Ocrevus 300 mg in 0.9% Sodium Chloride 250 ml. Infuse IV over approximately 2.5 hours or longer. Provide Doses 1 and 2: Ocrevus 300 mg IV infusion, followed two weeks later by second 300 mg IV infusion. Provide Dose 2 only: Ocrevus 300 mg IV infusion two weeks after first dose. Date first dose was completed:</p> <p>Subsequent doses (select one). Date last dose was administered:</p> <p>Ocrevus 600 mg in 0.9% Sodium Chloride 500 ml IV infusion once every 6 months. Infuse over approximately 3.5 hours or longer as tolerated. Infuse over approximately 2 hours or longer as tolerated (for patients with no prior serious infusion reactions with any previous Ocrevus infusion).</p>
Briumvi x1 year	<p>Has the patient completed a first dose of Briumvi? No. Provide the first dose. Yes, date completed:</p> <p>Provide Dose 1: Briumvi 150mg in 0.9% Sodium Chloride 250ml. Infuse IV over approximately 4 hours or longer.</p> <p>Provide Dose 2: Briumvi 450mg in 0.9% Sodium Chloride 250ml. Infuse IV over 1 hour or longer. Administer Dose 2 two weeks following Dose 1.</p> <p>Subsequent doses:</p> <p>Briumvi 450mg in 0.9% Sodium Chloride 250ml. Infuse IV once every 24 weeks over 1 hour or longer. Administer the first subsequent infusion 24 weeks after initial Dose 1. Date last dose was administered:</p>
Tysabri	<p>Submit prescriptions/orders through the TOUCH Prescribing Program (do not use this form): https://www.touchprogram.com/TTP/</p>
Premedication x1 year Administer 30 minutes prior to infusion	<p>Methylprednisolone: 100 mg (or an equivalent corticosteroid) administered as a slow intravenous (IV) push</p> <p>Acetaminophen: Adult & Pediatric >30kg: Dispense 325mg tablets #100 or 325mg/10.15ml UD oral solution #100. Administer 325mg PO. Pediatric 15-30kg: Dispense 160mg tablets #30 or 160mg/5ml oral solution 120ml. Administer 160mg PO. May repeat x1 if symptoms occur.</p> <p>DiphenhydrAMINE: Adult & Pediatric >30kg: Dispense 25mg capsules or tablets #100. Administer 50mg PO. May repeat x1 if symptoms occur. Pediatric 15-30kg: Dispense 25mg/10ml oral solution 120 ml. Administer 25mg PO. May repeat once if symptoms occur. Other (specify):</p>

This form is not a valid prescription in New York.

Multiple sclerosis biologic therapies referral form

Infusion Pharmacy Phone:

Fax:

✂ Please detach before submitting to a pharmacy - tear here.

Patient name:

DOB:

Ancillary Orders

Lab Orders, x1 year	Quantitative Serum Ig (A/E/G/M) HBV testing: H B sAg HBsAb (anti-HBs) HBcAb (anti-HBc) CBC w/differential CMP Creatinine/BUN Other
Nursing to draw at visit	Frequency of labs: Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs from a central catheter, the labs may be drawn peripherally. RN to flush IV access after each blood draw with Sodium Chloride 0.9% 20ml and use Heparin 10 units/ml 5ml (if port use Heparin 100 units/ml, 5ml) as final lock for patency.
Nursing Orders, x1 year	RN to complete assessment and administer therapy. RN to insert/maintain/remove peripheral IV (PIVC) or access central venous catheter as needed using aseptic technique. RN to rotate PIVC as needed for signs of infiltration/irritation. Flush PIVC with Sodium Chloride 0.9% 5mL pre infusion and post infusion. If port, RN to access with non-coring port needle using sterile technique. De-access after infusion and apply sterile pressure gauze and transparent dressing to site. RN to use sterile field Sodium Chloride 0.9% 10mL with needle change. Flush PORT with Sodium Chloride 0.9% 10mL pre infusion and post infusion. Use Heparin 100units/mL 5mL as final lock for patency. Flush port on treatment day, at least once monthly, and PRN to maintain line patency. Discontinue port maintenance upon discontinuation of pharmacy services.
Pharmacy Orders, x1 year	Pharmacy to dispense flushes, needles, syringes, HME/DME quantity sufficient to complete therapy as prescribed.

Anaphylaxis/Infusion Reaction Management Orders x1 year

Drug	Patient weight	Dose	Dispense detail	Directions*
DiphenhydrAMINE	Adult & Pediatric >30kg	50mg	Dispense 25mg capsules or tablets #4 Dispense 50mg vial for injection #1	For <u>mild</u> * symptoms, slow infusion 50% until symptoms resolve. Administer diphenhydrAMINE PO. For <u>moderate</u> * to <u>severe</u> * symptoms, stop infusion.
	Pediatric 15-30kg	25mg	Dispense 25mg/10ml oral solution 120 ml Dispense 50mg vial for injection #1	Administer diphenhydrAMINE slow IV push not to exceed rate of 25mg/min. May repeat x1 if symptoms persist. For <u>moderate</u> * symptoms, resume infusion at 50% previous rate IF symptoms resolve.
EPINEPHrine	Adult & Pediatric >30kg	0.3mg/0.3ml	Dispense 1mg vial for injection #2	For <u>severe</u> * symptoms (anaphylaxis), stop infusion. Disconnect tubing from access device to prevent further administration. Activate 911. Administer EPINEPHrine IM into lateral thigh x1. May repeat in 5-15 minutes if symptoms persist. Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status.
	Pediatric 15-30kg	0.15mg/0.15ml	Dispense 1mg/1ml vial for injection #2	
Sodium chloride 0.9% Injection, USP	Dispense 500 ml bag #1 For <u>severe</u> * symptoms, administer as IV gravity bolus (1000mL/hour).			
Other, specify				

*Mild symptoms include flushing, dizziness, headache, apprehension, sweating, palpitations, nausea, pruritus, and/or throat itching. Moderate symptoms include chest tightness, shortness of breath, >20 mmHg change in systolic blood pressure from baseline, and/or increase in temperature (>2°F). Severe symptoms include >40 mmHg change in systolic blood pressure from baseline, increase in temperature with rigors, shortness of breath with wheezing, and/or stridor.

Physician information

Name: _____ Practice: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____ NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible signature _____ Dispense as written signature _____ Date _____

Please fax: Completed form Demographic sheet/insurance information Clinical notes and labs HBV and IgG test results
 Please include ALL pages when faxing

This form is not a valid prescription in New York.