Multiple Sclerosis IV Infusion Enrollment Form



Phone: 877-778-0318 Fax Referral To: 877-778-0399 Email Referral To: info@ameripharma.us

(Date)

Six Simple Steps to Submitting a Referral							
OPATIENT INFORMATION (Complete or include demographic sheet) OPRESCRIBER INFORMATION							
	Patient Name:						
Address:			Prescriber's Name: State License #:		NPI #:		
City, State, ZIP:			DEA #:				
Preferred Contact	Phone (to primary # provided below)	Text Email (to cell # provided (to email provided below)	Group or Hospital:				
Method:	Note: Carrier charges	may apply. If unable to contact via text or email,	Address:				
Primary Phone:		ill attempt to contact by phone. ☐Home ☐Cell ☐Work	City, State, ZIP:				
Alternate Phone:			Phone:				
DOB:		— 5	Fax:				
Email:			Contact Person:				
Last Four of SSN:		Primary Language:	Contact's Phone:				
3INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back).							
4 DIAGNOSIS AND CLINICAL INFORMATION							
Needs by Date:							
Ship to: Patient Prescriber's Office AmeriPharma Infusion Center Other							
Infusion Site: Name Address:							
(Please include street address, suite #, city, state, ZIP)							
Diagnosis (ICD-10):							
G35 Multiple Sclerosis (MS) Description:							
G35 Multiple Sclerosis (MS)							
	Mio, piedo						
	First clinical epis	ode of MS; If so, does the patient have	MRI features consistent	with MS? 🔲 Y	′es □ No		
Height: inches/cm Weight:lbs/kg Allergies:							
MS drug(s) not able	Ü						
wis drug(s) not abid		senance trial duration	Г	Inadequate re	enoneo trial duration		
Drug:	□Inadequate response, trial duration □Intolerance, specify:		Drug:	☐Inadequate response, trial duration ☐Intolerance, specify:			
	Contraindication, specify:			Contraindication, specify:			
Drug:	☐Inadequate re	sponse, trial duration	Drug:	∐Inadequate re	esponse, trial duration		
	☐Intolerance, s	pecify:	☐Intolerance, spe		pecify:		
	Contraindication, specify: Contraindication, specify:						
Nursing and Administration:							
Place of Infusion: ☐ AmeriPharma Infusion Center ☐ Prescriber's Office ☐ Infusion site above							
SPRESCRIPTION INFORMATION							
			P DIDECTIONS		CHANTITY	DEELLO	
MEDICATION	STRENGT		& DIRECTIONS		QUANTITY	REFILLS	
☐ Lemtrada [®]		an MS One to One [®] /Lemtrada enrollment please contact MS One to One at 1-85		harma Specialty (Care as your preferred pharma	icy provider.	
	(For questions,	Induction Dose: Infuse 300 mg IV		oure Follow			
	300 mg/10 mL	with a second 300mg IV infusion	over approximately 2.5 h	ours two	☐ 2 vials		
☐ Ocrevus [™]	(30 mg/mL)	weeks later. Infusions may be int					
	single dose vial	☐ Maintenance Dose: Infuse 600 m					
		every 6 months. Infusions may b					
Diluent:	0.9%	Use as directed.			250 mL (induction)		
☐ Sodium Chloride	0.976				☐ 500 mL (maintenance)		
Premed Corticosteroid:		☐ 100mg administered IV approxim	ately 30 minutes prior to				
		each Ocrevus™ infusion.					
Premed Antihistamine:							
☐ Diphenhydramine							
<u> </u>	Places complete	on MS Touch®/Typobri annallmast for	m and indicate America	rma Chacialti:	Caro ac vous professed at	maev.	
☐ Tysabri [®]		e an MS Touch®/Tysabri enrollment for please contact TOUCH Prescribing Pro			Jare as your preferred pharr	пасу.	
П	to questions,	picase contact 1000111 lescribility Fit	ogram at 1-000-400-2200	/•			
☐ Patient is interested in patient s	unnort programs	STAMP SIGNATURE N	OT ALLOWED	Apoillary supp	lies and kits provided as needed for adminis	stration	
□ Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration							

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