Multiple Sclerosis IV Infusion Enrollment Form

ameripharma SPECIALTY CARE

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

Six Simple Steps to Submitting a Referral

❶PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____
Address: _____
City, State, ZIP: _____

Preferred Contact Method: ☐Phone (to primary # provided below) ☐Text (to cell # provided below) ☐Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
Email: _____
Last Four of SSN: _____ Primary Language: _____

❷PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact's Phone: _____

❸INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back).

❹DIAGNOSIS 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) ☐ Code: _____ Description: _____

If MS, please indicate type:
☐ Primary progressive MS (PPMS) ☐ Relapsing-remitting MS (RRMS) ☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No

Height: _____ inches/cm Weight: _____lbs/kg Allergies: _____

MS drug(s) not able to use:

Drug: _____
☐Inadequate response, trial duration _____
☐Intolerance, specify: _____
☐Contraindication, specify: _____

Drug: _____
☐Inadequate response, trial duration _____
☐Intolerance, specify: _____
☐Contraindication, specify: _____

Drug: _____
☐Inadequate response, trial duration _____
☐Intolerance, specify: _____
☐Contraindication, specify: _____

Drug: _____
☐Inadequate response, trial duration _____
☐Intolerance, specify: _____
☐Contraindication, specify: _____

Nursing and Administration:
Place of Infusion: ☐ AmeriPharma Infusion Center ☐ Prescriber's Office ☐ Infusion site above

❺PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
☐ Lemtrada®	Please complete an MS One to One®/Lemtrada enrollment form and indicate AmeriPharma Specialty Care as your preferred pharmacy provider. (For questions, please contact MS One to One at 1-855-676-6326).			
☐ Ocrevus™	300 mg/10 mL (30 mg/mL) single dose vial	☐ Induction Dose: Infuse 300 mg IV over approximately 2.5 hours. Follow with a second 300mg IV infusion over approximately 2.5 hours two weeks later. Infusions may be interrupted or slowed as needed. ☐ Maintenance Dose: Infuse 600 mg IV over approximately 3.5 hours every 6 months. Infusions may be interrupted or slowed as needed.	☐ 2 vials ☐ _____	
Diluent: ☐ Sodium Chloride	0.9%	Use as directed.	☐ 250 mL (induction) ☐ 500 mL (maintenance)	
Premed Corticosteroid: ☐ Methylprednisolone ☐ _____		☐ 100mg administered IV approximately 30 minutes prior to each Ocrevus™ infusion. ☐ _____		
Premed Antihistamine: ☐ Diphenhydramine ☐ _____				
☐ Tysabri®	Please complete an MS Touch®/Tysabri enrollment form and indicate AmeriPharma Specialty Care as your preferred pharmacy. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255).			
☐				

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

❻

X _____ PHYSICIAN SIGNATURE REQUIRED
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)