

NEUROLOGY ENROLLMENT FORM: INFUSION

PATIENT INFORMATION	
Last Name _____	First Name _____
Social Security No _____	Date of Birth _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Weight _____ Height _____ Allergies _____	
Home Phone _____	Work/Mobile _____
Home Address _____	

PATIENT INSURANCE INFORMATION	
Primary Medical Insurance _____	Medical Insurance Phone _____
Rx Card (PBM) _____	Group No _____
Prescription Card Bin # _____	PCN # _____

TREATMENT ARRANGEMENTS
•Start Date: _____ Ship Meds <input type="checkbox"/> Home <input type="checkbox"/> Doctor's Office Teaching by: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____

STATEMENT OF MEDICAL NECESSITY: Diagnosis: <input type="checkbox"/> G35 Multiple Sclerosis -> <input type="checkbox"/> Relapsing/Remitting <input type="checkbox"/> Progressive <input type="checkbox"/> _____ Date of Diagnosis: _____ •Is Patient using prescribed therapy in combination with other biologics for MS? <input type="checkbox"/> Yes <input type="checkbox"/> No •Is Patient pregnant, nursing, or planning pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Allergies: _____ Tried and failed Medications: _____ HEP-B Test Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____
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PRESCRIPTION INFORMATION				
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MEDICATION	DOSE FORM & STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Radicava®	<input type="checkbox"/> 300mg/100ml	<input type="checkbox"/> Initial Dose: 60mg IV daily for 14 days followed by 14-days drug free periods. <input type="checkbox"/> Subsequent Dose: 60mg IV daily for 10 days out of 14 day periods, followed by 14- day drug free periods x 1 year.
<input type="checkbox"/> Ocrevus®	<input type="checkbox"/> 300mg/10ml	<input type="checkbox"/> Loading Dose: 300mg IV at 0 and 2 weeks, <input type="checkbox"/> Subsequent Dose: 600 mg IV every 6 months. Protocol Pre-Medication Orders: Solu-Medrol 100mg IV and Anti-Histamine 25 mg PO to be given 30mins before infusion.
<input type="checkbox"/> Lemtrada®	<input type="checkbox"/> 12 mg/1.2ml vial	<input type="checkbox"/> Dose Titration:-Premedicate with corticosteroids. Must be diluted before admin. Day 1 infuse 12mg over 4 hrs.; Day (2 to 5) can infuse 12 mg over 2 hrs., may extend time if patient is not doing well; Admin antiviral agents for herpetic prophylaxis for minimum 2 months.
<input type="checkbox"/> Tysabri®	<input type="checkbox"/> 300mg/15ml	<input type="checkbox"/> 300mg Infused IV over one hour, every 4 weeks. <input type="checkbox"/> Other: _____
<input type="checkbox"/> Rituxan®	<input type="checkbox"/> 100mg/10ml <input type="checkbox"/> 500mg/50ml	<input type="checkbox"/> Loading Dose: 1000mg IV once and repeat in two weeks. <input type="checkbox"/> Maintenance Dose: 1000mg IV once every six months. <input type="checkbox"/> Other: _____
<input type="checkbox"/> Cyclophosphamide	<input type="checkbox"/> 800mg/m2	<input type="checkbox"/>

Physician Signature: _____ DAW (Dispense as Written) Date: _____

Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____

Physician Address: _____ NPI: _____ DEA: _____

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