NEUROLOGY ENROLLMENT FORM: INFUSION

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security No _____ Date of Birth _____

Sex □ M □ 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 □Home □ Doctor's Office

Teaching by: □ Doctor's Office□ Other: _____

STATEMENT OF MEDICAL NECESSITY: Diagnosis:□ G35 Multiple Sclerosis ->□ Relapsing/Remitting □ Progressive□-_____ Date of Diagnosis:_____

•Is Patient using prescribed therapy in combination with other biologics for MS? □ Yes □ No

•Is Patient pregnant, nursing, or planning pregnancy? □ Yes □ No □ N/A Allergies: _____

Tried and failed Medications:

HEP·B Test Result: □ Positive □ Negative Date: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE FORM & STRENGTH	DIRECTIONS	QUANTITY	REFILL
□ **Radicava®**	□ 300mg/100ml	□ **Initial Dose:** 60mg IV daily for 14 days followed by 14-days drug free periods. □ **Subsequent Dose:** 60mg IV daily for 10 days out of 14 day periods, followed by 14-day drug free periods x 1 year.		
□ **Ocrevus®**	□ 300mg/10ml	□ **Loading Dose:** 300mg IV at O and 2 weeks, □ **Subsequent Dose:** 600 mg IV every 6 months. Protocol Pre-Medication Orders: Solu-Medrol IOOmg IV and Anti-Histamine 25 mg PO to be given 30mins before infusion.		
□ **Lemtrada®**	□ 12 mg/1.2ml vial	□ **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; Adm in antiviral agents for herpetic prophylaxis for minimum 2 months.		
□ **Tysabri®**	□ 300mg/15ml	□ 300mg Infused IV over one hour, every 4 weeks. □ Other:		
□ **Rituxan®**	□ 100mg/10ml □ 500mg/50ml	□ **Loading Dose:** 1000mg IV once and repeat in two weeks. □ **Maintenance Dose:** 1000mg IV once every six months. □ Other:_____		
□ **Cyclophosphamide**	□ 800mg/m2	□		

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

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

Physician Address:_____ **NPI:**_____ **DEA:** _____

By Signing this prescription and using Southside pharmacy's services you authorize Southside Pharmacy to contact Insurance companies for prior authorization purposes on your behalf

FAXTO (855) - 822 - 7838

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