Multiple Sclerosis IV/SC Infusion
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance: _____ **ID No:** _____ **RX GRP:** _____ **RX BIN:** _____ **RX PCN:** _____

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10) and Patient Clinical Information:
Drug Allergies: _____ ☐ NKDA **Ht:** _____ in/cm **Wt:** _____ lbs/Kg

Diagnosis (ICD-10): ☐ G35 Multiple Sclerosis (MS) ☐ Other: _____ 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
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ YES ☐ NO

MS drug(s) Trialed and Failed: Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____

If Applicable, **please indicate Pregnancy Results:** ☐ POSITIVE **(+)** ☐ NEGATIVE **(-)**

Labs: Please fax copy of the following labs dated within 1 year: ☐ **CMP** ☐ **CBCw/ diff** ☐ **IgG/ IgG Subclasses** ☐ **Hep-B** ☐ **MRI**

4 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILLS
☐ **Briumvi**	150 mg/6 mL vial	Administer 150 mg in 250 mL NS IV over 4 hours minimum. For second and subsequent Infusion; administer 450 mg IV in 250 mL NS over 1 hour minimum at week 2, Then repeat every 24 Weeks, following day 1 starting dose.	Quantity: **Q.S**	Refills: ____
☐ **Ocrevus**	300 mg/10 mL	Infuse 300 mg in 250 mL NS IV over 2.5 hours minimum at weeks 0 and 2. Then Infuse 600 mg in 500 mL NS IV over 2 hours minimum every 6 months.	Quantity: **Q.S**	Refills: ____
☐ **Ocrevus Zunovo**	920 mg ocrelizumab + 23,000U hyaluronidase /23 mL	Administer 23 mL of OCREVUS ZUNOVO subcutaneously in the abdomen over approximately 10 minutes every 6 months	Quantity: **Q.S**	Refills: ____

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ Diphenhydramine: ☐ PO ☐ IV	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial**	Refills: **PRN**
☒ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **500 mL**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☒ **NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.
☒ **INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.
FLUSHING PROTOCOL: ☒ Sodium chloride 0.9%, Upt to 10 mL before/after medication, and/or PRN to maintain patency.
☐ Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency
☒ **LABS:** *[Dx code: Z79.899]*; Labs to be drawn by RN prior to infusion every _____ ☐ Week ☐ Month(s), as followed:
☐ **CMP** ☐ **CBC w/ diff** ☐ **IgG Total** ☐ **IgG Subclasses 1-4** ☐ **Hepatitis (B)** ☐ **Other:** _____

5 PRESCRIBER INFORMATION

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____
Address: _____ **City/ State/ Zip:** _____
Phone: _____ **Fax:** _____ **Contact Person:** _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
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Physicians signature **Date**

THANK YOU FOR YOU TRUSTING US IN YOUR PATIENTS SPECIALTY CARE *#welcome to our family*