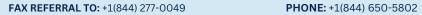
## Multiple Sclerosis IV/SC Infusion REFERRAL FORM





Т	PAIIE	NI SINFO	ORMATION (Complete or include demographic sheet)			
	Patient Name	:	DOB: Ge	ender: MALE	FEMALE	
			City/State/Zip:			
			Email: Primary L			
			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:						
			ID No: RX GRP: RX BIN:	RX PCN:_		
3	DIAGN	NOSIS ANI	O CLINICAL INFORMATION			
	Diagnosis (IC	D-10) and Patient Cli	nical Information:			
	Drug Allergies:		in	ı/cm <b>Wt:</b>	lbs/Kg	
	Diagnosis (ICI	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: Inadequate response, trial duration Intolerance, specify: Intolerance, s						
	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 Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG/ IgG Subclasses Improvements the following labs dated within 1 year: CMP CBCw/ diff IgG/ IgG/ IgG/ IgG/ IgG/ IgG/ IgG/ IgG/					
4 PRESCRIPTION INFORMATION						
	MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILLS	
	_		Administer 150 mg in 250 mL NS IV over 4 hours minimum. For second and	-		
	Briumvi	150 mg/6 mL vial	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.	0	D-fille.	
			Infuse 300 mg in 250 mL NS IV over 2.5 hours minimum at weeks 0 and 2. Then Infuse	Quantity: <b>Q.S</b>	Refills:	
	Ocrevus	_	600 mg in 500 mL NS IV over 2 hours minimum every 6 months.	Quantity: <b>Q.S</b>	Refills:	
	Ocrevus Zunovo	920 mg ocrelizumab + 23,000U hyaluronidase	Administer 23 mL of OCREVUS ZUNOVO subcutaneously in the abdomen over			
	Zunovo	/23 mL	approximately 10 minutes every 6 months	Quantity: <b>Q.S</b>	Refills:	
	PRE/POST ORDERS:					
	ME	DICATION	DIRECTION	QUANTITY	REFILLS	
	Diphenhyd	Iramine: PO IV	Administer mg 30-60 min Prior to Infusion. May repeat every hours PRN.	Quantity: <b>Q.S</b>	Refills: PRN	
	Acetamino	phen <b>(PO)</b>	dminister mg PO 30-60 min Prior to Infusion. May repeat every hours PRN.	Quantity: <b>Q.S</b>	Refills: PRN	
	ANAPHYLAXIS PROTOCOL:					
	MEDICATION  EPINEPHRINE (vial or autoinjector)		DIRECTION  Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes	QUANTITY	REFILLS	
			□ 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)	Defiller DDN	
			Administer via IM or slow IV push for severe anaphylactic reaction.	(xz) Feli(s)	Refills: PRN	
	DIPHENHY	DRAMINE (50mg/mL)	50 mg (Wt > 30 kg) 25 mg (Wt 15-30 kg) 12.5mg (Wt 7.5-15kg)	Quantity: (x1) Vial	Refills: <b>PRN</b>	
	X SODIUM CH	HLORIDE 0.9% (IV)	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: <b>500 mL</b>	Refills: PRN	
NURSING/ LABS/ INFUSION SUPPLIES:						
NURSING: Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide educat INFUSION SUPPLIES: Infusion supplies and infusion pump PRN for the administration and disposal of medication.					lab draws.	
		TOCOL: X Sodium chlori	ride 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					
		X LABS: [Dx code: Z79.899]; Labs to be drawn by RN prior to infusion every				
5						
Э	PRESCRIBER INFORMATION					
	Prescriber Name: Title: MD DO ND PA APRN NPI:					
			City/ State/ Zip:			
	Phone:		Fax: Contact Person: he best of my knowledge, with supporting documentation in the patient's medical record.			
l 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 funderstand that I can revoke the designation at any time by providing written notice to IV Solutions RX.				ime prescription for the patient	listed above. I	
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		@ivsolutionsrx.com and destroy all				

Physicians signature

Date #welcome to our family