Multiple Sclerosis IV/SC 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 SIGNATURE REQUIRED (***STAMP SIGNATURE NOT ALLOWED***)

Prescriber Name: _____ **Title:** ☐ **MD** ☐ **DO** ☐ **ND** ☐ **PA** ☐ **APRN** **NPI:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Fax:** _____ **Contact Person:** _____

☐ **DISPENSE AS WRITTEN** ☐ **BRAND MEDICALLY NECESSARY** ☐ **DO NOT SUBSTITUTE**
☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE**

Prescriber's Signature: _____ **Date:** _____

☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible**

Prescriber's Signature: _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

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.

CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

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