Multiple sclerosis biologic therapies referral form

Infusion Pharmacy Phone: 1-877-342-9352 Fax: 1-888-594-4844

✂ Please detach before submitting to a pharmacy - tear here.

Care specialist Name: Phone:

Patient information ☐ see attached ☐ PEDIATRIC (Younger than 13 years, or less than 45kg in weight)

Patient name: Gender: ○ M ○ F DOB:

Address: City: State: ZIP:

Phone: Cell:

Emergency contact: Phone: Relationship:

Insurance: Attach image insurance card (front and back)

Primary diagnosis ICD-10 code Diagnosis: ☐ Primary progressive ☐ Active Secondary Progressive ☐ Isolated Syndrome ☐ Relapsing remitting

Medical assessment Height in inches: Weight **in kg only:** Date weight **(in kg)** obtained:

Clinical documentation attached for the following:

☐ Current medication list ☐ Serum Ig level
☐ Allergies ☐ Venous access device
☐ TB test results ☐ Clinical note describing tried and failed therapies
☐ Hepatitis B panel

☐ Indicate if first lifetime dose needed in the home setting; if not a first dose please indicate when next dose is due

Prescription and orders

Medication infused via rate controlled device per manufacturer guidelines as tolerated by patient, not to exceed maximum rate listed.

Medication	**Dose and directions** (select all that apply)
Ocrelizumab, intravenous (Ocrevus) **x1 year**	**Doses 1 and 2:** Ocrevus 300 mg in 0.9% Sodium Chloride 250 ml. Infuse IV over approximately 2.5 hours or longer. ☐ Provide Doses 1 and 2: Ocrevus 300 mg IV infusion, followed two weeks later by second 300 mg IV infusion. ☐ Provide Dose 2 only: Ocrevus 300 mg IV infusion two weeks after first dose. **Date first dose was completed:** **Date last dose was administered:** **Subsequent doses (select one).** Ocrevus 600 mg in 0.9% Sodium Chloride 500 ml IV infusion once every 6 months. ☐ Infuse over approximately 3.5 hours or longer as tolerated. ☐ Infuse over approximately 2 hours or longer as tolerated (for patients with no prior serious infusion reactions with any previous Ocrevus infusion).
Ocrelizumab and hyaluronidase-ocsq, subcutaneous (Ocrevus Zunovo)	☐ Ocrevus Zunovo 920 mg ocrelizumab / 23,000 units hyaluronidase 23 mL vial, administer 23 mL subcutaneously into the abdomen over 10 minutes once every 6 months
Briumvi **x1 year**	**Has the patient completed a first dose of Briumvi?** ☐ **Provide Dose 1:** Briumvi 150mg in 0.9% Sodium Chloride 250ml. Infuse IV over approximately 4 hours or longer. ☐ **Provide Dose 2:** Briumvi 450mg in 0.9% Sodium Chloride 250ml. Infuse IV over 1 hour or longer. Administer Dose 2 two weeks following Dose 1. **Subsequent doses:** ☐ Briumvi 450mg in 0.9% Sodium Chloride 250ml. Infuse IV once every 24 weeks over 1 hour or longer. Administer the first subsequent infusion 24 weeks after initial Dose 1.
Tysabri	Submit prescriptions/orders through the TOUCH Prescribing Program (do not use this form): https://www.touchprogram.com/TTP/
Premedication **x1 year** **Administer 30 minutes prior to infusion**	☐ Methylprednisolone: 100 mg (or an equivalent corticosteroid) administered as a slow intravenous (IV) push ☐ Oral dexamethasone 20 mg ☐ Acetaminophen: Adult & Pediatric >30kg: Dispense 325mg tablets #100 or 325mg/10.15ml UD oral solution #100. Administer 325mg PO. Pediatric 15-30kg: Dispense 160mg tablets #30 or 160mg/5ml oral solution 120ml. Administer 160mg PO. May repeat x1 if symptoms occur. ☐ DiphenhydrAMINE: Adult & Pediatric >30kg: Dispense 25mg capsules or tablets #100. Administer 50mg PO. May repeat x1 if symptoms occur. Pediatric 15-30kg: Dispense 25mg/10ml oral solution 120 ml. Administer 25mg PO. May repeat once if symptoms occur. ☐ Other (specify):

This form is not a valid prescription in Arizona or New York.

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Ancillary Orders

Lab Orders, x1 year Nursing to draw at visit	☐ Quantitative Serum Ig (A/E/G/M) ☐ HBV testing: ☐ H B sAg ☐ HBsAb (anti-HBs) ☐ HBcAb (anti-HBc) ☐ CBC w/differential ☐ CMP ☐ Creatinine/BUN ☐ Other Frequency of labs: Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs from a central catheter, the labs may be drawn peripherally. RN to flush IV access after each blood draw with Sodium Chloride 0.9% 20ml and use Heparin 10 units/ml 5ml (if port use Heparin 100 units/ml, 5ml) as final lock for patency.
Nursing Orders, x1 year	RN to complete assessment, administer therapy, and monitor patient per product prescribing information/ manufacturer guidelines. **Peripheral**: RN to insert, maintain, and remove peripheral IV (PIVC) as needed using aseptic technique. Flush PIVC with Sodium Chloride 5 mL pre and post infusion. **Implanted Port:** RN to access port with non-coring needle using sterile technique and sterile field 0.9 % Sodium Chloride 10mL during needle changes. Flush port with 0.9% Sodium Chloride 10 mL pre and post infusion followed by final lock with Heparin 100 unit/mL 5mL. De-access port after infusion and flush with Heparin 100 unit/mL 5mL at least every 12 weeks to maintain patency. Discontinue port maintenance upon discontinuation of pharmacy services.
Pharmacy Orders, x1 year	Pharmacy to dispense flushes, needles, syringes, HME/DME quantity sufficient to complete therapy as prescribed.

☑ **Anaphylaxis/Infusion Reaction Management Orders** x1 year

Drug	Patient weight	Dose	Dispense detail	Directions*
DiphenhydrAMINE	Adult & Pediatric >30kg	50mg	Dispense 25mg capsules or tablets #4 Dispense 50mg vial for injection #1	For mild* symptoms, slow infusion rate by 50% until symptoms resolve. Administer diphenhydrAMINE PO. For moderate* to severe* symptoms, stop infusion. Administer diphenhydrAMINE slow IV push not to exceed rate of 25mg/min. For moderate* symptoms, may resume infusion at 50% previous rate IF symptoms resolve.
	Pediatric 15-30kg	25mg	Dispense 25mg/10ml oral solution 120 ml Dispense 50mg vial for injection #1	
EPINEPHrine	Adult & Pediatric >30kg	0.3mg/0.3ml	Dispense 1mg vial for injection #2	For severe* symptoms (anaphylaxis), stop infusion. Disconnect tubing from access device to prevent further medication administration. Activate 911. Administer EPINEPHrine IM into lateral thigh x1. May repeat in 5-15 minutes if symptoms persist. Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status.
	Pediatric 15-30kg	0.15mg/0.15ml	Dispense 1mg/1ml vial for injection #2	
Other, specify				

*Mild symptoms include flushing, dizziness, headache, apprehension, sweating, palpitations, nausea, pruritus, and/or throat itching. Moderate symptoms include chest tightness, shortness of breath, >20 mmHg change in systolic blood pressure from baseline, and/or increase in temperature (>2°F). Severe symptoms include >40 mmHg change in systolic blood pressure from baseline, increase in temperature with rigors, shortness of breath with wheezing, and/or stridor.

Physician information

Name: Practice:

Address: City: State: ZIP:

Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible signature Dispense as written signature Date

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and labs ☐ HBV and IgG test results

Please include ALL pages when faxing

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