Multiple Sclerosis Infusion Agents

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

Patient Information

Patient name: _____ DOB: _____

Sex: ☐ Female ☐ Male SSN: _____

Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate: _____

Caregiver name: _____ Relation: _____

Local pharmacy: _____ Phone: _____

Insurance plan: _____ Plan ID: _____

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____

NPI: _____

Address: 1151 Old York Road

Apt/Suite: 200 City: Abington State: PA Zip: 19001

Contact: _____

Phone: 215-957-9250 Alternate: _____

Fax: 215-957-9254

Email: _____

Ship To: ☐ Prescriber's Office ☐ Infusion Site

Infusion Site Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ _____ Diagnosis Date: _____

Type: ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Secondary-progressive ☐ Primary-progressive ☐ Progressive-relapsing

Hepatic Impairment present: ☐ Yes ☐ No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____

Pre-existing hepatic conditions: ☐ HBV ☐ HCV ☐ _____ HBV Test: ☐ HBsAg+ ☐ HBcAb+ ☐ Both Negative Test date: _____

Has patient received an MS infusion product previously? ☐ Yes ☐ No

If yes, product information: _____ Date of last infusion: _____ Date of next infusion: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription		Quantity		Refill
☐ **Lemtrada®** (alemtuzumab)	To order Lemtrada®, please see the Genzyme form at lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf Phone: 855-676-6326 Fax: 855-557-2478			
☐ **Ocrevus™** (ocrelizumab)	☐ Infuse 300 mg intravenously over no less than 2.5 hours on day 1 and day 15.	☐ 2 x 300 mg/10mL	Vials	0
	☐ Infuse 600 mg intravenously over no less than 3.5 hours 6 months after the day 1 infusion and every 6 months thereafter.	☐ 2 x 300 mg/10mL	Vials	1

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

Reset Form