

Multiple Sclerosis Infusion Agents



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: _____
 Apt/Suite: _____ City: _____ State: _____ Zip: _____
 Contact: _____
 Phone: _____ Alternate: _____
 Fax: _____
 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____

Concomitant Medications: _____

Allergies: NKDA Other: _____

		Quantity	Refill
Lemtrada® (alemtuzumab)	To order Lemtrada®, please see the Genzyme form at lemtradarems.com/Docs/Pdf/lemtadra_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 [SC Ig](#).

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.

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