

# Multiple Sclerosis Infusion Agents



Patient Information		Prescriber + Shipping Information											
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>		Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ Ship To: <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Infusion Site Infusion Site Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____											
Clinical Information (Please fax all pertinent clinical and lab information)													
<b>Diagnosis:</b> <input type="checkbox"/> G35 (Multiple Sclerosis) <input type="checkbox"/> _____ Diagnosis Date: _____ Type: <input type="checkbox"/> Clinically isolated syndrome <input type="checkbox"/> Relapsing-remitting <input type="checkbox"/> Secondary-progressive <input type="checkbox"/> Primary-progressive <input type="checkbox"/> Progressive-relapsing Hepatic Impairment present: <input type="checkbox"/> Yes <input type="checkbox"/> No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____ Pre-existing hepatic conditions: <input type="checkbox"/> HBV <input type="checkbox"/> HCV <input type="checkbox"/> _____ HBV Test: <input type="checkbox"/> HBsAg+ <input type="checkbox"/> HBcAb+ <input type="checkbox"/> 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 _____ _____ _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 5px;">Approximate Start Date</th> <th style="text-align: left; padding: 5px;">Approximate End Date</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table>		Approximate Start Date	Approximate End Date	_____	_____	_____	_____	_____	_____
Approximate Start Date	Approximate End Date												
_____	_____												
_____	_____												
_____	_____												
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____													
Prescription		Quantity		Refill									
<b>Lemtrada®</b> (alemtuzumab)		To order Lemtrada®, please see the Genzyme form at <a href="http://lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf">lemtradarems.com/Docs/Pdf/lemtrada_rems_prescription_ordering_form.pdf</a> Phone: 855-676-6326 Fax: 855-557-2478											
<b>Ocrevus™</b> (ocrelizumab)		Infuse 300 mg intravenously over no less than 2.5 hours on day 1 and day 15.		2 x 300 mg/10mL	Vials								
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	0								
_____		_____		_____	_____								
_____		_____		_____	_____								
_____		_____		_____	_____								
For patients requiring immune globulin therapy, please fill out the respective form: <a href="#">IVIg</a> or <a href="#">SCLg</a> .													
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____													
<i>Stamp signature not allowed, physician signature required.</i>													
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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