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|  | | 625 S Pear Orchard Ridgeland, MS 39157  Phone: 769-233-8484 Fax: 769-233-8051 | | Multiple Sclerosis  IV Infusion Enrollment Form | | |
| **Patient Information** | | | **Prescriber Information** | | | |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Prescriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Gender: 🞎 Male 🞎 Female Last 4 of SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Insurance Information** (Please fax a copy of patient’s card including front and back) | | | | | | |
| **Medical Information** (Please attach clinical notes) | | | | | | |
| 🞎 G35 Multiple Sclerosis 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Has pregnancy been excluded: 🞎 Yes 🞎 No 🞎 Not Applicable | | | |
| 🞎 Relapsing Remitting 🞎 Primary Progressive | | | Prior Therapies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 🞎 Progressive Relapsing 🞎 Secondary Progressive | | | Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Diagnosis Date: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ lb Height:\_\_\_\_\_\_\_ in | | | Therapy: 🞎 New 🞎 Reauthorization 🞎 Restart | | | |
| Date of Last MRI: \_\_\_\_\_\_\_\_\_\_ MRI Changes: 🞎 Yes 🞎 No | | | Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Prescription Information** | | |  | | | |
| **Medication** | **Dose/ Strength** | | **Directions** | | **Quantity** | **Refills** |
| 🞎 Solu-medrol | 🞎 1 gm vial  🞎 Other \_\_\_\_\_\_\_\_\_\_ | | 🞎 Infuse IV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Infuse 1 gm IV every 24 hrs x 3 days  🞎 Infuse 1 gm IV every 24 hrs x 4 days  🞎 Infuse 1 gm IV every 24 hrs x 5 days | | 🞎 QS day supply |  |
| 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 \_\_\_\_\_\_\_\_\_ | | 🞎 Infuse IV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Infuse \_\_\_ mg IV every \_\_\_ hrs x \_\_\_ days | | 🞎 QS day supply |  |
| 🞎 Anaphylaxis kit | epinephrine 0.3mg/0.3ml (adult) Prefilled Syringe  diphenhydramine 50mg/ 1ml vial | | Inject epinephrine 0.3 mg into thigh IM or SQ in case of anaphylaxis.May repeat if needed.  Inject diphenhydramine 50 mg IM or IV in case of anaphylaxis. | | 1 |  |
| 🞎Diphenhydramine | 🞎 25 mg tab  🞎 50 mg/ml vial | | 🞎 \_\_\_ mg PO every \_\_\_ hours prn  🞎 \_\_\_ mg IV every \_\_\_ hours prn | | 🞎 QS day supply |  |
| 🞎Acetaminophen | 🞎 325 mg tab | | 🞎 \_\_\_ mg PO every \_\_\_ hours prn | | 🞎 QS day supply |  |
| 🞎 Bloodwork | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_  🞎 BMP  🞎 CMP  🞎 CBC | | 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Before 1st infusion | |  |  |
| Prescriber’s Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Product Substitution Permitted Date Dispense as Written Date | | | | | | |
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Version 1