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|   | 625 S Pear Orchard Ridgeland, MS 39157Phone: 769-233-8484 Fax: 769-233-8051 | Multiple SclerosisIV 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 Syringediphenhydramine 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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