

Multiple Sclerosis Infusion Agents



Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	Ship To: <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Infusion Site
Please fax a copy of front and back of the insurance card(s).	Infusion Site Name: _____
	Address: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ Fax: _____

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <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	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> 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
Tysabri® (natalizumab)	To order Tysabri®, please see Enrollment form the TOUCH Program at https://www.touchprogram.com/TTP/ Phone: 1-800-456-2255 Fax: 1-800-840-1278	

For patients requiring immune globulin therapy, please fill out the respective form: [IVIg](#) or [SCLg](#).

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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