VEROS HEALTH®
Excellence in Complex Care

MULTIPLE SCLEROSIS REFERRAL FORM

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician's name:
Address:	License #: NPI #:
City: State: Zip:	DEA #:
Home Phone: Other Phone:	Address:
Email:	City: State: Zip:
DOB: Social Security #:	Office Contact:
Gender: ☐ M ☐ F Height: Weight:	Phone: Fax:
Allergies: _____	

3. **DIAGNOSIS:** G35 Multiple Sclerosis	
Has the patient been previously treated for this condition? ☐ Yes ☐ No Has the patient tried and failed medication? ☐ Yes ☐ No Is the patient currently on therapy? ☐ Yes ☐ No Number of relapses in the past year: _____	Last MRI date: _____ Any Changes? ☐ Yes ☐ No SCr: _____ CrCL: _____ TB Test: ☐ Positive ☐ Negative Hepatitis B virus screening: ☐ Yes ☐ No **Novantrone®**: Is patients LVEF <50% ☐ Yes ☐ No **Infuse 12mg/m2 every 3 months** What is the lifetime (cumulative) Novantron® dose? _____mg/m2 Please provide a copy of last CBC w/ diff.; date _____ If Kesimpta® prescribed, provide quantitative serum IG screening ☐ Is patient pregnant or nursing ☐ Yes ☐ No

4. INSURANCE INFORMATION: Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION

☐ Ocrevus™	300mg/10ml vial*	☐ Initial dosing: Infuse 300 mg IV as directed followed two (2) weeks later by a second 300 mg IV dose ☐ Subsequent dosing: Infuse 600 mg IV as directed every six (6) months *Each 300 mg dose must be diluted in 250 mls of 0.9% Sodium Chloride for injection	4 week supply	_____ refills
☐ Kesimpta®	20 mg Prefilled Syringe 20 mg Pen	☐ Initial Dosing: 20 mg SC administered at Week 0, 1, and 2 ☐ Subsequent Dosing: 20 mg SC administered monthly starting at Week 4	4 week supply	_____ refills
☐ Tysabri®	300mg/15ml vial*	Infuse 300 mg IV over 1 hour every 4 weeks *Each 300 mg must be diluted in 100 mls of 0.9% Sodium Chloride for injection	4 week supply	_____ refills
☐ Avonex®	30mcg Prefilled Syringe #4 30mcg Pen #4	Inject 30mcg IM once weekly Week 1: 7.5mcg (0.125ml) IM Week 2: 15mcg (0.25ml) IM Week 3: 22.5 mcg (0.375ml) IM Week 4: 30mcg (0.5ml) IM	4 week supply	_____ refills

☐ Betaseron® ☐ Extavia®	0.3mg vial 0.3mg vial	☐ Dose Titration: Weeks 1-2: inject 0.0625mg/0.25ml SQ every other day Weeks 3-4: inject 0.125mg/0.50ml SQ every other day Weeks 5-6: inject 0.1875mg/0.75ml SQ every other day Weeks 7+: inject 0.25mg/1ml SQ every other day ☐ Maintenance: inject 0.25mg/1ml SQ every other day	4 week supply	_____ refills
☐ Copaxone®	20mg Prefilled Syringe 40mg Prefilled Syringe	☐ 20mg SQ daily ☐ 40mg SQ 3 times per week	4 week supply	_____ refills
☐ Gilenya®	0.5mg capsules 0.25mg capsules	☐ 0.5 mg po once-daily in adults and pediatric patients 10 years of age and older weighing more than 40 kg ☐ 0.25 mg po once daily in pediatric patients 10 years of age and older weighing less than or equal to 40 kg	4 week supply	_____ refills
☐ Rebif®	☐ 8.8mcg Prefilled Syringe or Autoinjector ☐ 22mcg Prefilled Syringe or Autoinjector ☐ 44mcg Prefilled Syringe or Autoinjector	☐ Weeks 1-2: inject 8.8mcg SQ three times per week ☐ Weeks 3-4: inject 22mcg SQ three times per week ☐ Weeks 5+: (48 hrs apart): inject 44mcg SQ three times per week ☐ Week 1-2: inject 4.4mcg (0.1ml) SQ three times per week ☐ Week 3-4: inject 11mcg (0.25ml) SQ three times per week ☐ Maintenance: inject 22mcg (0.5ml) SQ three times per week	4 week supply 4 week supply	_____ refills _____ refills

Premeds: ☐ Methylprednisolone _____ ☐ Diphenhydramine _____
Ship to: ☐ Prescribers Office ☐ Patient's Home | Injection Training completed by: _____

6. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*
Age 1-5: 12.5mg IV/PO x1 **Age 6-11**: 25mg IV/PO x1 **Age 12+:** 50mg IV/PO x1
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: ________________________

Labs: ________________________

8. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): ____ Date: _____

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Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.