Your Health, True Wealth

Multiple Sclerosis Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes,plus lab results for last 3 months, to:
f: 818-882-8929

PATIENT INFORMATION

Patient Name		DOB	Contact Phone
Address	City	State	Zip
Gender ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐Allergies		
ICD-10 code:		ICD-10 description:	
Patient Status ☐ New to Therapy ☐ Continuing Therapy		TB Skin Test ☐Yes ☐No	Hepatitis B Screen ☐Yes ☐No

PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐Insurance Cards	☐History & Physical	☐Most Recent Labs	☐Medication List

MULTIPLE SCLEROSIS TREATMENT PLAN

☐ Ocrevus™	300mg/10ml vial*	☐ Initial dosing: Infuse 300 mg IV as directed followed two weeks later by a second 300 mg IV dose ☐ Subsequent dosing: Infuse 600 mg IV as directed every 6 months
☐ Ocrevus Zunovo™	920mg+23,000 units hyaluronidase per 23mL vial*	☐ Initial dosing: Inject 920mg subcutaneously in the abdomen over 10 minutes ☐ Subsequent dosing: Inject 920mg subcutaneously every 6 months following initial injection
☐ Briumvi®	150mg/6ml vial*	☐ Initial Dosing: 150mg IV day 1 and then 450mg on day 15 Subsequent Dosing: 450mg/250ml NS q 24weeks ☐
☐ Tysabri®	300mg/15ml vial*	Infuse 300 mg IV over 1 to 2 hours every ____ weeks
☐ Other	Include dosage, frequency and any other special instructions.	
☐ Refill for 1 year		

PREMEDICATION

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

PREMEDICATION	LABORATORY ORDERS
☐ Include premedication per Northridge Pharmacy Specialty & Infusion's infusion protocol. ☐ Other _____	☐ CBC every _____ ☐ CMP every _____ ☐ Other

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929.

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____