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:

p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

This form is not a valid prescription

- - - - ✂ - - Please detach before submitting to a pharmacy. Cut or tear here. - - - -

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		Date
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		

NURSING

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

☐ Include premedication per Pharmacy's infusion protocol.

☐ Other ______________________________

LABORATORY ORDERS

☐ CBC every __________

☐ CMP every __________

☐ Other

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.

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