

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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
<input type="checkbox"/> NKDA	<input type="checkbox"/> Allergies		Date
ICD-10 code:		ICD-10 description:	
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B Screen <input type="checkbox"/> Yes <input type="checkbox"/> No	
PRESCRIBER INFORMATION			
Ordering Prescriber		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address		City	State Zip
REQUIRED DOCUMENTATION			
<input type="checkbox"/> Insurance Cards	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Most Recent Labs	<input type="checkbox"/> Medication List
MULTIPLE SCLEROSIS TREATMENT PLAN			
<input type="checkbox"/> Ocrevus™	300mg/10ml vial*	<input type="checkbox"/> Initial dosing: Infuse 300 mg IV as directed followed two weeks later by a second 300 mg IV dose <input type="checkbox"/> Subsequent dosing: Infuse 600 mg IV as directed every 6 months	
<input type="checkbox"/> Ocrevus Zunovo™	920mg+23,000 units hyaluronidase per 23mL vial*	<input type="checkbox"/> Initial dosing: Inject 920mg subcutaneously in the abdomen over 10 minutes <input type="checkbox"/> Subsequent dosing: Inject 920mg subcutaneously every 6 months following initial injection	
<input type="checkbox"/> Briumvi®	150mg/6ml vial*	<input type="checkbox"/> Initial Dosing: 150mg IV day 1 and then 450mg on day 15 <input type="checkbox"/> Subsequent Dosing: 450mg/250ml NS q 24weeks	
<input type="checkbox"/> Tysabri®	300mg/15ml vial*	Infuse 300 mg IV over 1 to 2 hours every ____ weeks	
<input type="checkbox"/> Other	Include dosage, frequency and any other special instructions.		
<input type="checkbox"/> 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		LABORATORY ORDERS	
<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol. <input type="checkbox"/> Other _____		<input type="checkbox"/> CBC every _____ <input type="checkbox"/> CMP every _____ <input type="checkbox"/> 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.