elixir
SPECIALTY PHARMACY

Multiple Sclerosis Infusion Enrollment Form
Phone: 1-877-437-9012   Fax 1-877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ______________________________
Date of Birth: __/__/____ Sex: M or F SS#______________
Address: ______________________________
City: ______________State:______Zip:__________
Home Phone: ___________ Work Phone: ____________
Cell Phone: _____________ E-mail:______________
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ______________________
Insurance Company Phone: ______________________
Policyholder:______________________________
Policy holder Employer:_________________________
Relationship to Patient:_________________________
ID# ______________Group#_________________
RxBIN: _______________RxPCN:______________

Prescriber Information

Practice/ Organization Name: ____________________
Physician Name:____________________________
Address:_________________________________
City: ______________State: _______Zip: _________
Phone#:____________Fax#:__________________
DEA#_________________NPI#_______________
License#:_____________Medicaid UPIN#:__________
Physician Specialty: ___________________________
Date Shipment Needed: __/__/____ Attn: _____________
Ship to: ☐Patient ☐Prescriber ☐Infusion Clinic
Shipment Address: ____________________________
City: _______________State: _______Zip:_________
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

☐ **SKILLED NURSING** visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. Frequency based on prescription dose orders.

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Clinical Information and Prescription

Diagnosis: ☐G35 Multiple Sclerosis ☐Other:______________________________
If MS, please indicate type: ☐ Primary progressive MS (PPMS) ☐ Relapsing-remitting MS (RRMS) ☐ Progressive-relapsing MS ☐ Secondary progressive MS (SPMS) ☐ Clinically Isolated Syndrome
Date of Diagnosis or Years with Disease: _________ Patients Allergies:______________________
Patient Weight: ________ kgs or lbs (*please indicate*) Patient Height: ________ inches or cm. (*please indicate*)
Prior Treatments with duration and reason for discontinuation ______________________________

☐ **Ocrevus® (ocrelizumab)**

☐ Initial titration:
Mix Ocrevus 300 mg/10 mL in NS 250 mL & infuse IV over at least 2.5 hours on Day 1 and Day 15;
Dispense 300 mg #2
Start at 30 mL/hr for 30 minutes; increase rate by 30 mL/hr Q 30 min until max rate of 180 mL/hr reached

☐ Subsequent infusions:
Mix Ocrevus 600 mg/20 mL in NS 500 mL & infuse IV over at least 3.5 hours every 6 months;
Dispense 300 mg #2
Start at 40 mL/hr for 60 minutes; increase rate by 40 mL/hr Q 30 min until max rate of 200 mL/hr reached

Refills Authorized: ☐ 0 ☐ 1

☐ **Tysabri® (natalizumab)** to order Tysabri please call the TOUCH program at 800-456-2255
Mix Tysabri 300mg/15ml in NS 100ml & infuse IV over 1 hour
Dispense 300mg #1
Refills Authorized: ☐ 0 ☐ 1 ☐ 3 ☐ 6 ☐ Other: ___

Lemtrada® (alemtuzumab) to order please call MS One to One at 855-676-6326

Dose	Directions	Quantity	Refills
☐**Acetaminophen** ☐325mg ☐ 500mg ☐ **Diphenhydramine** ☐ 25mg ☐ 50mg	☐ Take _____ mg p.o. 30-60min. prior to inf. and q4-6hr prn. Maximum of 4 doses in 24 hrs. ☐ ______________________	☐ Qty:	☐ 11 ☐ ___
☐ **Epinephrine** ☐ 0.3mg auto-injector ☐0.15mg auto-injector	Inject IM p.r.n anaphylaxis	☐ Qty:	☐ 1 ☐ ___
☐ NaCl 0.9% 10ml flush	Flush line with 10ml, before and after infusion and p.r.n line care.	☐ Qty:	☐ 11 ☐ ___
☐ Heparin 100U/ml 5ml PFS ***for central line patients**	Flush line with 5ml after final saline flush.	☐ Qty:	☐ 11 ☐ ___
☐ Emla cream- lidocaine 2.5% /prilocaine 2.5%	Apply topically to needle insertion site, 30-60 minutes prior to infusion.	☐ Qty:	☐ 11 ☐ ___
☐ Hydration fluid	0.9% NS ______ mL infused over ______ minutes Timing: ____ minutes ☐ pre IG ☐ post IG ☐ during IG	☐ Qty:	☐ 11 ☐ ___
☐Other:	☐ Sig:	☐ Qty:	☐ ___

X____ Date: ____/____/______
Physician Signature (no stamps) For No Substitution allowed, please indicate "DAW" here: ______________

Updated September 2023