Multiple Sclerosis
Enrollment Form - Page 1 of 2

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

Diagnosis Date: ______________________

TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION OF PRESCRIBED MULTIPLE SCLEROSIS THERAPY

If YES, please provide the following information:

Last Infusion Date: ______________________

Next Infusion Date: ______________________

If NO, please indicate desired location for first dose:

☐ Physician's Office
☐ TwelveStone Infusion Suite
☐ TwelveStone Home Infusion
☐ Enroll in Manufacturer Nurse Training

Desired Start Date: ______________________

DIAGNOSIS

Description	*ICD-10Code*
Multiple Sclerosis	☐ G35
Other/Supporting Diagnosis: ___________________________	☐ Other ICD 10: ____

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed}*

☐ This signed order form ☐ History and Physical ☐ Tysabri Touch Authorization ☐ TB and Hep B Documentation

☐ Patient Demographics and Insurance Information ☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight:_____________ Kg/Lbs Height:_______________ Inches/CM BSA:_______________ Allergies:_______________________________________

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size_____Gauge_____Length) ☐ Sub-Q

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS
☐ Avonex	☐ Vial ☐ Pen ☐ Syringe	☐ Titration - Inject SQ 7.5mcg week 1, 15mcg week 2, 22.5mcg week 3, and 30mcg weekly thereafter ☐ Maintenance - Inject SQ 30mcg weekly	
☐ Copaxone	☐ 20mg	Inject SQ once daily	
	☐ 40mg	Inject SQ 3 times weekly	
☐ Glatopa	20mg	Inject SQ once daily	
☐ Tysabri	300mg	Infuse Intravenously over 1 hour every 4 weeks	Liver Function Tests q _______
☐ Lemtrada	12mg	☐ 1st Course – Infuse intravenously over 4 hours daily x 5 days ☐ 2nd Course – Infuse intravenously over 4 hours daily x 3 days	Thyroid Fxn Tests – q 3 months CBC with Diff monthly x 48 months
☐ Ocrevus	600mg	☐ Start – Infuse intravenously over 2.5 hours 300mg week 0, then 300mg week 2 ☐ Maintenance – Infuse 600mg over 3.5 hours every 6 months	
☐ Aubagio	☐ 7mg ☐ 14mg	Take one table daily	CBC with Diff q _______
☐ Gilenya	0.5mg	Take 1 tablet daily	
☐ Tecfidera	☐ 120mg	Starter – Take 1 tablet by mouth twice daily x 7 days	
	☐ 240mg	Maintenance – Take 1 tablet by mouth twice daily	
☐ Plegridy	☐ Starter Pack Syr ☐ Starter Pack Pen	Inject 63mcg on day 1, 94mcg on day 15, and 125mcg on day 29	Liver Function Tests q ______ CBC with Diff q ______
	☐ 125mcg Syr ☐ 125mcg Pen	Inject SQ every 14 days	
☐ Rebif	☐ Titration Kit 22 mcg ☐ Titration Kit 44mcg	☐ Inject SQ 3 times weekly – 4.4mcg weeks 1-2, 11mcg weeks 3-4, 22mcg week 5 and thereafter ☐ Inject SQ 3 times weekly – 8.8mcg weeks 1-2, 22mcg weeks 3-4, 44mcg week 5 and thereafter	Liver function Tests q ______ CBC with Diff q ______
	☐ 22mcg ☐ 44mcg	Inject SQ 3 times weekly	
☐ Zynbrita	150mg	Inject SQ once a month	Liver Function Tests q ______
☐ Rituxan	100mg/10ml	Infuse _______ mg IV infusion over _______ minutes daily	CBC with Diff q ______
☐ Betaseron	0.3 mg	Titration – Inject 0.0625mg (0.25ml) SQ every other day, and increase over a 6 week period	Liver Function Tests q ______ CBC with Diff q ______
		Maintenance – Inject 0.25mg (1ml) every other day	
☐ Solu-Medrol	1Gm Vial	Infuse _______ mg IV infusion over _______ minutes daily	

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Premedication(s):

- ☐ Diphenhydramine 25-50 mg po- 25mg #2 per dose
- ☐ Acetaminophen 325-650 mg po– 325mg #2 per dose
- ☐ Methylprednisolone_______mg IV over_______mins
- ☐ Other: ____

Ancillary Orders:

- ☐ NaCl 0.9% 5-lOml IV before and after infusion
- ☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
- ☐ Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
- ☐ All infusion supplies necessary to administer the medication
- ☐ Anaphylaxis Kit

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________	______________________	______________________	______________________
Dispense as Written	Date	Substitution Allowed	Date

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