# 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<br>☐ Pen<br>☐ Syringe | ☐ Titration - Inject SQ 7.5mcg week 1, 15mcg week 2, 22.5mcg week 3, and 30mcg weekly thereafter<br>☐ 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<br>☐ 2nd Course – Infuse intravenously over 4 hours daily x 3 days | Thyroid Fxn Tests – q 3 months<br>CBC with Diff monthly x 48 months |
| ☐ Ocrevus | 600mg | ☐ Start – Infuse intravenously over 2.5 hours 300mg week 0, then 300mg week 2<br>☐ Maintenance – Infuse 600mg over 3.5 hours every 6 months | |
| ☐ Aubagio | ☐ 7mg<br>☐ 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<br>☐ Starter Pack Pen | Inject 63mcg on day 1, 94mcg on day 15, and 125mcg on day 29 | Liver Function Tests q _______<br>CBC with Diff q _______ |
| | ☐ 125mcg Syr<br>☐ 125mcg Pen | Inject SQ every 14 days | |
| ☐ Rebif | ☐ Titration Kit 22 mcg<br>☐ Titration Kit 44mcg | ☐ Inject SQ 3 times weekly – 4.4mcg weeks 1-2, 11mcg weeks 3-4, 22mcg week 5 and thereafter<br>☐ Inject SQ 3 times weekly – 8.8mcg weeks 1-2, 22mcg weeks 3-4, 44mcg week 5 and thereafter | Liver function Tests q _______<br>CBC with Diff q _______ |
| | ☐ 22mcg<br>☐ 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 _______<br>CBC with Diff q _______ |
| | | Maintenance – Inject 0.25mg (1ml) every other day | |
| ☐ Solu-Medrol | 1Gm Vial | Infuse _______ mg IV infusion over _______ minutes daily | |

**Multiple Sclerosis**
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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**

| ______________________ | ______________________ | ______________________ | ______________________ |
|---|---|---|---|
| Physician's Phone# | Physician's NPI# | Physician's Fax# | Physician's Address |

| ______________________ | ______________________ | ______________________ | ______________________ |
|---|---|---|---|
| Dispense as Written | Date | Substitution Allowed | Date |

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