# Multiple sclerosis biologic therapies referral form

Optum

**Optum Infusion Pharmacy** Phone: Fax:

✂ Please detach before submitting to a pharmacy – tear here.

**Care specialist** Name: Phone:

## Patient information ☐ see attached ☐ PEDIATRIC (Younger than 13 years, or less than 45kg in weight)



Patient name: Gender: ○ M ○ F DOB: Last 4 of SSN:

Address: City: State: ZIP:

Phone: Cell:

Emergency contact: Phone: Relationship:

**Insurance** ☐ Front and back of insurance cards to follow

Primary Insurance: Phone: Policy #: Group:

Secondary Insurance: Phone: Policy #: Group:

**Primary diagnosis** ICD-10 code Diagnosis: ☐ Primary progressive ☐ Active Secondary Progressive ☐ Isolated Syndrome ☐ Relapsing remitting

**Medical assessment** Height in inches: Weight **in kg only:** Date weight **(in kg)** obtained:

Current medications? ○ Yes ○ No If yes, list or attach:

Allergies:

HBV most recent testing date:*

Serum Ig most recent testing date:*

*Attach test results and clinical evaluation notes, as applicable. Include rationale for any tests not performed. Note in orders below if requesting lab draws at infusion nurse visit.

Tried and failed therapies: include supportive clinical documents.

**IV Access:** ○ **PIV** ○ **CVAD** ○ **Implantable port**

## Prescription and orders Medication infused per the drug PI recommended rate and via rate controlled device per therapy

| **Medication** | **Dose and directions** (select all that apply) |
|---|---|
| **Ocrevus**<br>**x1 year** | **Doses 1 and 2:** Ocrevus 300 mg in 0.9% Sodium Chloride 250 ml. Infuse IV over approximately 2.5 hours or longer.<br>☐ Provide Doses 1 and 2: Ocrevus 300 mg IV infusion, followed two weeks later by second 300 mg IV infusion.<br>☐ Provide Dose 2 only: Ocrevus 300 mg IV infusion two weeks after first dose. **Date first dose was completed:**<br>**Subsequent doses (select one).** **Date last dose was administered:**<br>Ocrevus 600 mg in 0.9% Sodium Chloride 500 ml IV infusion once every 6 months.<br>☐ Infuse over approximately 3.5 hours or longer as tolerated.<br>☐ Infuse over approximately 2 hours or longer as tolerated (for patients with no prior serious infusion reactions with any previous Ocrevus infusion). |
| **Briumvi**<br>**x1 year** | **Has the patient completed a first dose of Briumvi?** ○ No. Provide the first dose. ○ Yes, date completed:<br>☐ **Provide Dose 1:** Briumvi 150mg in 0.9% Sodium Chloride 250ml. Infuse IV over approximately 4 hours or longer.<br>☐ **Provide Dose 2:** Briumvi 450mg in 0.9% Sodium Chloride 250ml. Infuse IV over 1 hour or longer.<br>Administer Dose 2 two weeks following Dose 1.<br>**Subsequent doses:**<br>☐ Briumvi 450mg in 0.9% Sodium Chloride 250ml. Infuse IV once every 24 weeks over 1 hour or longer.<br>Administer the first subsequent infusion 24 weeks after initial Dose 1. **Date last dose was administered:** |
| **Tysabri** | Submit prescriptions/orders through the TOUCH Prescribing Program (do not use this form):<br>https://www.touchprogram.com/TTP/ |
| **Premedication**<br>**x1 year**<br>**Administer 30 minutes prior to infusion** | ☐ Methylprednisolone: 100 mg (or an equivalent corticosteroid) administered as a slow intravenous (IV) push<br>☐ Acetaminophen:<br>Adult & Pediatric >30kg: Dispense 325mg tablets #100 or 325mg/10.15ml UD oral solution #100. Administer 325mg PO.<br>Pediatric 15-30kg: Dispense 160mg tablets #30 or 160mg/5ml oral solution 120ml. Administer 160mg PO.<br>May repeat x1 if symptoms occur.<br>☐ DiphenhydrAMINE:<br>Adult & Pediatric >30kg: Dispense 25mg capsules or tablets #100. Administer 50mg PO. May repeat x1 if symptoms occur.<br>Pediatric 15-30kg: Dispense 25mg/10ml oral solution 120 ml. Administer 25mg PO. May repeat once if symptoms occur.<br>☐ Other (specify): |

**This form is not a valid prescription in Arizona or New York.**

 

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## Ancillary Orders

| | |
|---|---|
| **Lab Orders, x1 year**<br>Nursing to draw at visit | ☐ Quantitative Serum Ig (A/E/G/M) ☐ HBV testing: ☐ H B sAg ☐ HBsAb (anti-HBs) ☐ HBcAb (anti-HBc)<br>☐ CBC w/differential ☐ CMP ☐ Creatinine/BUN ☐ Other<br>Frequency of labs:<br>Lab work to be obtained via IV access using aseptic technique. If RN is not able to draw labs from a central catheter, the labs may be drawn peripherally. RN to flush IV access after each blood draw with Sodium Chloride 0.9% 20ml and use Heparin 10 units/ml 5ml (if port use Heparin 100 units/ml, 5ml) as final lock for patency. |
| **Nursing Orders, x1 year** | RN to administer prescribed medication.<br>RN to initiate access device (insert peripheral IV or access central catheter).<br>RN to flush IV post infusion with 5ml 0.9% NaCl.<br>As a final lock for patency, RN to use heparin 10unit/ml, 3ml or if port, heparin 100unit/ml, 5ml. |
| **Pharmacy Orders, x1 year** | Pharmacy to dispense flushes, needles, syringes, HME/DME quantity sufficient to complete therapy as prescribed. |

☑ **Anaphylaxis/Infusion Reaction Management Orders** x1 year

| Drug | Patient weight | Dose | Dispense detail | Directions* |
|---|---|---|---|---|
| DiphenhydrAMINE | Adult & Pediatric >30kg | 50mg | Dispense 25mg capsules or tablets #4<br>Dispense 50mg vial for injection #1 | For mild* symptoms, slow infusion 50% until symptoms resolve. Administer diphenhydrAMINE PO.<br>For moderate* to severe* symptoms, stop infusion.<br>Administer diphenhydrAMINE slow IV push not to exceed rate of 25mg/min. May repeat x1 if symptoms persist.<br>For moderate* symptoms, resume infusion at 50% previous rate IF symptoms resolve. |
| | Pediatric 15-30kg | 25mg | Dispense 25mg/10ml oral solution 120 ml<br>Dispense 50mg vial for injection #1 | |
| EPINEPHrine | Adult & Pediatric >30kg | 0.3mg/0.3ml | Dispense 1mg vial for injection #2 | For severe* symptoms (anaphylaxis), stop infusion. Disconnect tubing from access device to prevent further administration. Activate 911. Administer EPINEPHrine IM into lateral thigh x1.<br>May repeat in 5-15 minutes if symptoms persist. Administer CPR if needed until EMS arrives. Contact prescriber to communicate patient status. |
| | Pediatric 15-30kg | 0.15mg/0.15ml | Dispense 1mg/1ml vial for injection #2 | |
| Sodium chloride 0.9% Injection, USP | Dispense 500 ml bag #1 For severe* symptoms, administer as IV gravity bolus (1000mL/hour). | | | |
| Other, specify | | | | |

*Mild symptoms include flushing, dizziness, headache, apprehension, sweating, palpitations, nausea, pruritus, and/or throat itching. Moderate symptoms include chest tightness, shortness of breath, >20 mmHg change in systolic blood pressure from baseline, and/or increase in temperature (>2°F). Severe symptoms include >40 mmHg change in systolic blood pressure from baseline, increase in temperature with rigors, shortness of breath with wheezing, and/or stridor.

## Physician information

Name: Practice:

Address: City: State: ZIP:

Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible signature Dispense as written signature Date

**Please fax:** ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and labs ☐ HBV and IgG test results

Please include ALL pages when faxing

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