

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	Ship To: <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Infusion Site
Please fax a copy of front and back of the insurance card(s).	Infusion Site Name: _____
	Address: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ Fax: _____

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: G35 (Multiple Sclerosis) _____		Diagnosis Date: _____	
Type: Clinically isolated syndrome	Relapsing-remitting	Secondary-progressive	Primary-progressive
Progressive-relapsing			
Hepatic Impairment present: Yes	No	AST: _____ U/L	ALT: _____ U/L
Bilirubin: _____ mg/dL		Lab date: _____	
Pre-existing hepatic conditions: HBV HCV _____ HBV Test: HBsAg+ HBcAb+ Both Negative Test date: _____			
Has patient received an MS infusion product previously? Yes No			
If yes, product information: _____ Date of last infusion: _____ Date of next infusion: _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____

Concomitant Medications: _____

Allergies: NKDA Other: _____


Prescription			
Lemtrada[®] (alemtuzumab)	<input type="checkbox"/> Infuse 12mg in 100ml NS IV daily over approx 4 hours for 5 consecutive days (total 60mg)	Dispense: #5 - 12mg vials	Refills: 0
	<input type="checkbox"/> Infuse 12mg in 100ml NS IV daily over approx 4 hours for 3 consecutive days (total 60mg) <small>**Each treatment cycle will begin 12 months from 1st day of prior cycle**</small>	Dispense: #3 - 12mg vials	Refills: 0
Ocrevus[™] (ocrelizumab)	To order Ocrevus, see Ocrevus referral form		
Tysabri[®] (natalizumab)	To order Tysabri, fill out Touch form and fax to CoxHealth at Home		

For patients requiring immune globulin therapy, please fill out the respective form: [IVlg](#) or [SClg](#).

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____



I authorize CoxHealth at Home, and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1 855-419-4663 to obtain instructions as to the proper destruction of the transmitted material. Thank you.