CoxHealth at Home

Multiple Sclerosis Infusion Agents

PHONE: 1-855-419-4663
FAX: 1-417-269-0692

Patient Information

Patient name: _____ DOB: _____

Sex: ❑ Female ❑ Male SSN: _____

Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in

Address: _____

Apt/Suite:_____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate: _____

Caregiver name: _____ Relation: _____

Local pharmacy: _____ Phone: _____

Insurance plan: _____ Plan ID: _____

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____

NPI: _____

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Contact: _____

Phone: _____ Alternate: _____

Fax: _____

Email: _____

Ship To: ❑ Prescriber's Office ❑ Infusion Site

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 ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ❑ NKDA ❑ Other: _____

Prescription

Lemtrada® (alemtuzumab)	❑ Infuse 12mg in 100ml NS IV daily over approx 4 hours for 5 consecutive days (total 60mg)	Dispense: #5 - 12mg vials	Refills: 0
	❑ Infuse 12mg in100ml NS IV daily over approx 4 hours for 3 consecutive days (total 60mg) **Each treatment cycle will begin 12 months from 1st day of prior cycle**	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: IVIg or SCIg.

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.