

**Patient Information**

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

**Additional Information Needed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs                 |
| <input type="checkbox"/> Fax patient demographics         | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

**Diagnosis and Clinical Information**
**Diagnosis (ICD-10):**

- G35 Multiple Sclerosis  
 Type:  Relapsing-Remitting     Primary-Progressive     Secondary-Progressive     Progressive-Relapsing  
 Other: Code: \_\_\_\_\_ Description: \_\_\_\_\_

**Clinical Information:**

- New Therapy Induction     Therapy Change     Therapy Continuation  
 Patient Weight: \_\_\_\_\_ lbs / \_\_\_\_\_ kg  
 Patient Height: \_\_\_\_\_ in / \_\_\_\_\_ cm  
 Allergies: \_\_\_\_\_  
 Therapies Tried and Failed: \_\_\_\_\_  
 TB Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Hep B Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Does patient have history of life threatening reaction to Lemtrada?     Yes     No

**Last Brain MRI:**

Date: \_\_\_\_\_

**Date and Dose of Last:**

- Avonex: \_\_\_\_\_  
 Betaseron: \_\_\_\_\_  
 Lemtrada: \_\_\_\_\_  
 Ocrevus: \_\_\_\_\_  
 Rebif: \_\_\_\_\_  
 Tysabri: \_\_\_\_\_

**Lab Orders**

- CBC     CMP     ESR     CRP     HBsAg     HBsAB     HBcAB     Quantiferon Gold  
 Other: \_\_\_\_\_

**Lab Orders to be done by**

- Oklahoma Infusion Services  
 Referring Provider

**Prescription Information**

- Lemtrada    Initial Treatment of 2 Courses:  
 Dose: Course # 1: 12mg/day for 5 consecutive days  
 Dose: Course # 2: 12mg/day for 3 consecutive days 12 months after Course # 1

**Pre-Medication Orders**

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Solu-Medrol 1000mg IV            | <input checked="" type="checkbox"/> Benadryl 25mg IV Push (SIVP) |
| <input checked="" type="checkbox"/> Tylenol tablet 500-1000mg PO PRN | <input checked="" type="checkbox"/> Claritin 10mg PO PRN         |
| <input checked="" type="checkbox"/> Zantac 150mg PO PRN              | <input type="checkbox"/> Other: _____                            |

**Standing Orders for Adverse Reactions**

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Stop infusion and initiate NS bolus                    | <input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis    |
| <input checked="" type="checkbox"/> Notify supervising physician and ordering provider     | <input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula                       |
| <input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction       | <input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness |
| <input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation | <input type="checkbox"/> Other: _____   |

**Prescriber Information**


Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:


Prescriber's Signature: \_\_\_\_\_


Date: \_\_\_\_\_

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Please fax form to: 405-726-9849

 **Edmond**  
 1701 Renaissance Blvd, Ste 110  
 Edmond, OK 73013  
**Phone:** (405) 844-4978

 **Enid**  
 825 E Owen K Garriott Rd  
 Enid, OK 73701  
**Phone:** (580) 701-2586

 **Tulsa**  
 6135 S 90th E Ave  
 Tulsa, OK 74133  
**Phone:** (539) 215-5609