Specialty Injections Order Form
Multiple Sclerosis

Date: ______________

61 Doctor's Park • Cape Girardeau, MO 63703
866-936-1999 • Fax (573) 335-7233

Prescriber's Name: ______________ MD / DO / NP / PA
Address: ______________
City ______________ State ______________ Zip ______________
Office Contact: ______________ Phone# ______________ Fax# ______________
NPI: ______________ DEA: ______________ License: ______________

PATIENT INFORMATION

Send updates to ❑ Fax ❑ E-mail to ______________ ❑ Text to Phone# ______________

Patient's Name: ______________ SS# ______________ DOB: ______________
Address: ______________ City ______________ State ______________ Zip ______________
Home Phone: ______________ Work or Cell: ______________ Emergency Contact: ______________
Allergies: ______________ Sex: M___ F___ Wt: ______________ Ht: ______________ Diabetic: Y N
Patient previously on treatment: Y N Date next dose due: ______________
Primary Insurance: ______________ Policy# ______________
Insured: ______________ Group ______________
Phone: ______________ BIN# ______________ PCN# ______________

*** Please include current patient medication list with referral ***

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:

❑ **340** - multiple sclerosis
❑ Other - **Please Indicate ICD9_CM code:** ________ **description:** ______________

Medical History:

Did patient receive other medical therapies in the last 6 mos.? ❑ Yes ❑ No If yes, date: ______________ Therapies: ______________

Other medical history: ❑ Cardiac Disease ❑ Diabetes

Current Medications: ______________

AVONEX® (interferon beta-1a)
28 Day Supply
❑ **Usual regimen:** 30mcg intramuscular once weekly.
❑ Other Regimen: ______________
Refill x ____

BETASERON® (interferon beta-1b)
28 Day Supply
❑ **Usual regimen:** Follow initial titration regimen, then 0.25mg subcutaneously every other day.
❑ Other Regimen: ______________
Refill x ____

COPAXONE® (glatiramer)
28 Day Supply
❑ **Usual regimen:** 20mg subcutaneously daily.
❑ Other Regimen: ______________
Refill x ____

NOVANTRONE® (mitoxantrone)
❑ Administer 12mg/m² (___mg) in50ml NSS or D5W intravenously over 5-15 min every 3 months.
❑ Other regimen: ______________
Saline PFS 10ml Flush before and after infusion #qs Refill prn
Heparin 100u/ml 3-5ml Flush after infusion #qs Refill prn
Refill x ____

REBIF® (interferon beta-1a)
28 Day Supply
❑ **Usual Regimen:** Follow initial titration regimen, the 44 mcg subcutaneously 3x/week.
❑ Other regimen: ______________
Refill x ____

SOLU-MEDROL® (methylprednisolone)
Administer ____ gm in ____ ml Dextrose 5% or ____ ml 0.9% Normal Saline over ____ hours* for ____ days.
Saline PFS 10ml Flush before and after infusion #qs Refill prn
Heparin 100u/ml 3-5ml Flush after infusion #qs Refill prn
**Note: infuse no faster thatn 500mg/hour*

TYSABRI® (natalizumab)
❑ **Usual regimen:** 300mg in 100ml NaCl intravenously over 1 hour monthly.
❑ Other regimen: ______________
**Note: Patient must be enrolled in the TOUCH™ prescribing program (1-800-456-2255)*
❑ Date last ms. medication ______________
Saline PFS 10ml Flush before and after infusion #qs Refill prn
Heparin 100u/ml 3-5ml Flush after infusion #qs Refill prn
Refill x ____

❑ Duration of therapy: ____ ❑ days ❑ months (6-12)
❑ Is this the first dose? Yes No If no, date first dose given: ______________ ❑ start ASAP ❑ Next dose due: ______________

Orders:
❑ TEACHING — Instruct patient/caregiver about all aspects of their therapy and the s/s of complications.
❑ NURSING VISIT — Nurse to assess for signs and symptoms every ______________
TB status: ❑ Active TB ❑ PPD (-) date: ______________ ❑ Last CXR date: ______________ ❑ unknown
DNR status: ❑ Rc'd ❑ N/A

Other Orders:

Premedications
❑ Diphenhydramine (Benadryl®) 25mg Orally 30 minutes before infliximab infusion
❑ Acetaminophen (Tylenol®) 650 mg Orally 30 min before infliximab infusion
❑ Methylprednisolone (Solu-Medrol®) 60 mg IV
❑ Prednisone 40 mg ORALLY

Adverse Reactions
❑ Acetaminophen (Tylenol®) 650 mg ORALLY for fever or mild discomfort.
❑ Diphenhydramine (Benadryl®) 50 mg ORALLY for mild to moderate allergic reactions
❑ **EpiPen or Epinepherine 0.3mg SQ for anaphylactic reactions and contact physician.**
Authorized x1 year

By signing this form and utilizing our services, you are authorizing SDHC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: ______________ (May Substitute) ______________ (Dispense as Written) Date: ______________