Care Fusion INFUSION CENTERS

Neurology – Multiple Sclerosis Fax: 855-733-9898
Phone: 877-460-3905

Patient Information
Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment:
Diagnosis (ICD-10):
- ❑ G35A Relapsing-remitting MS
- ❑ G35B_____ (0,1, or 2) Primary progressive MS
- ❑ G35C_____ (0, 1 or 2) Secondary progressive MS
- ❑ G35D MS, unspecified
- ❑ G710.36 Limb-girdle muscular dystrophy due to fukutin-related dysfunction

History:
Has the patient previously been treated for this condition?
□ Yes □ No

Medications Failed: _____

Allergies: _____

Pre-Medication Orders:
- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion.
  □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: _____ To be Drawn by: □ Infusion Clinic □ Referring Provider

Medication

Briumvi (ublituximab-xiiy)
- ❑ Initial Dosing: 150mg IV x 1 dose then 450mg IV at week 2
- ❑ Maintenance Dosing: 450mg IV 24 weeks after the first infusion and every 24 weeks thereafter.
- ❑ **Maintenance Refills**: _____

*** Pre-medications of Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion **

Lemtrada (alemtuzumab)
- ❑ First treatment course: 12mg IV daily for 5 consecutive days
- ❑ Sequential treatment course: 12mg IV daily for 3 consecutive days, 12 months after previous dose
- ❑ **Maintenance Refills**: _____

Ocrevus (ocrelizumab)
- ❑ Initial Dosing: 300 mg IV given at week 0 and 2.
- ❑ Maintenance Dosing: 600mg IV every 6 months.
- ❑ **Maintenance Refills**: _____

*** Pre-medications of Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion ***

Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)
- ❑ Initial Dosing: 920mg/23,000u SC on day/week 0
- ❑ Maintenance Dosing: 920mg/23,000u SC every 6 months.
- ❑ **Maintenance Refills**: _____

*** Pre-medications of Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion ***

Tysabri (natalizumab)
Dosage:
- ❑ Tysabri 300mg IV every 4 weeks
- ❑ **Maintenance Refills**: _____

*** Ensure patient has Notice of Patient Authorization on file and completed Pre-Infusion Checklist per Biogen Idec ***

Physician Prescription Orders Address: _____ Phone: _____
Fax: _____ Clinic Contact: _____ Physician Name: _____
NPI # _____ ***Physician Signature:*** _____ ***Date:*** _____