

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:

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 OrdersAddress:

Physician Prescription OrdersAddress: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ **Physician Signature:** _____ **Date:** _____