

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

- ☐ G35.A Relapsing-remitting multiple sclerosis
☐ G35.B0 Primary progressive multiple sclerosis, unspecified
☐ G35.B1 Active primary progressive multiple sclerosis
☐ G35.B2 Non-active primary progressive multiple sclerosis

- ☐ G35.C0 Secondary progressive multiple sclerosis
☐ G35.C1 Active secondary progressive multiple sclerosis G35.C2 Non-active secondary progressive multiple sclerosis G35.D Multiple sclerosis, unspecified
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel depending on medication), signed prescription order and recent visit notes.
Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- ☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: JCV Antibody, Current MS Drug _____
Other: _____

Tysabri Administration (Select one):

☐ Infuse 300 mg IV over 60 minutes every 4 weeks.

☐ Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ Refills: ☐ zero ☐ 6 months ☐ 12 months ☐ _____ (Prescription valid for one year, unless otherwise indicated)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date