CureStat Rx
Home Infusion and Specialty Pharmacy

MULTIPLE SCLEROSIS INFUSION REFERRAL FORM

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Please fax a copy of front and back of the insurance card(s).

Clinical Information (Please fax pertinent lab information)

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ Other (ICD-10 code with description): _____ Diagnosis Date: __ __/__ __/__ __ __ __
Type: ☐ Primary-progressive ☐ Secondary-progressive ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Progressive-relapsing
Has pregnancy been excluded: ☐ Yes ☐ No ☐ Not Applicable Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in
Hepatic impairment present: ☐ Yes ☐ No AST: _____U/L ALT: _____U/L Bilirubin: _____mg/dL Lab date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of therapy	Start date	End Date

Allergies: ☐ NKDA ☐ Other: _____
Comorbidities: _____
Concomitant Medications: _____

Drug	Dose/Strength	Directions	Qty	Refills
LEMTRADA (alemtuzumab)				
OCREVUS (ocrelizumab)	300mg/10mL Vial	**Starter Dose:** Infuse 300 mg intravenously over no less than 2.5 hours on day 1 and day 15.		
		Maintenance Dose: Infuse 600 mg intravenously over no less than 3.5 hours every 6 months.		
Premedication: **Methylprednisolone** Other: _____	Other: _____	Infuse 100 mg IV approximately 30 mins prior to Ocrevus Other: _____		
Premedication **Diphenhydramine** Other: _____	Other: _____	Other: _____		

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____