

**Patient information**

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbs**Diagnosis**

- Relapsing-remitting multiple sclerosis, ICD 10: g35.a
- Active primary progressive multiple sclerosis, ICD 10: g35.b
- Non-active primary progressive multiple sclerosis, ICD 10: g35.b2
- Active progressive secondary multiple sclerosis, ICD 10: g35.c1
- Clinically isolated syndrome (cis), ICD 10: g36.9
- Other \_\_\_\_\_

**Allergies**  NKDA  \_\_\_\_\_**Medication instructions****Pre-medications**

- N/A
- Provider prescribed: \_\_\_\_\_

**Medication order****Dose**

- Initial treatment: 300 mg at week 0 and 2, then 600 mg every 6 months
- Initial treatment: 300 mg at week 0 and 2, then 600 mg every 24 weeks
- Maintenance treatment: 600 mg every 6 months
- Maintenance treatment: 600 mg every 24 weeks
- Other \_\_\_\_\_

**Frequency**

- N/A
- Other \_\_\_\_\_

**Medication route**

- IV
- Other \_\_\_\_\_

**Lab order**

(Include frequency)

Please list any labs to be drawn by the infusion clinic:

- N/A
- \_\_\_\_\_

**Prerequisites**

Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative Hep B test results | Baseline liver function tests (LFTs) (alt, ast, bilirubin, alkaline phosphatase) within 6 months

**Please send to**

- Columbia, MD
- Silver Spring, MD
- Bowie, MD
- Frederick, MD

**Referring provider information**

Referring provider name \_\_\_\_\_

NPI \_\_\_\_\_

Practice name \_\_\_\_\_

Point of contact Name \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_