

Patient information

Patient name _____

DOB _____

Mobile number _____

Weight _____ kgs lbs

Diagnosis Relapsing-remitting multiple sclerosis, ICD 10: g35.a
 Active secondary progressive 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	Frequency
	<input type="checkbox"/> First infusion: 150 mg IV; second infusion: 450 mg IV two weeks after first infusion; then 450 mg IV 24 weeks after first infusion; then every 24 weeks thereafter	N/A
	<input type="checkbox"/> Option 450 mg IV every 24 weeks	<input type="checkbox"/> Other _____
	<input type="checkbox"/> 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 | Baseline liver function tests (LFTs) (alt, ast, bilirubin, alkaline phosphatase) within 6 months | Negative Hep B test results

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** _____