Phone: 801-408-5700
Fax: 801-408-5741

ROCKY MOUNTAIN
Multiple Sclerosis Clinic

370 East 9th Ave Ste 106
Salt Lake City, UT 84103

INFUSION REFERRAL ORDER FORM

Patient Information

Name: _____
DOB: _____
Phone #: _____
Address: _____
_____
Touch ID : _____ NA

Provider Information

Referring Physician: _____
Practice Address: _____
_____
Office Contact Name: _____
Office Phone #: _____
Office Fax #: _____
Provider NPI/TIN:

Insurance Information (please attach cards)

Primary Insurance: _____ Policy ID #: _____
Secondary Insurance _____ Policy ID #: _____

MEDICATION ORDER

Medication	Dosing		Frequency		
☐ Tysabri	☐ 300 mg		☐ Q28 Days	☐ Q ____ Days	☐ Other_____
☐ Ocrevus	☐ 300 mg	☐ 600 mg	☐ Q2 Weeks	☐ Q24 Weeks	☐ Other_____
☐ Briumvi	☐ 150 mg	☐ 450 mg	☐ Q2 Weeks	☐ Q24 Weeks	☐ Other_____
☐ Other					

Indication/Diagnosis: *

☐ (G35) Multiple Sclerosis
☐ Other: _____
***ICD-10 (required):** _____

Notes (Additional Info)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

In Order for RMMSC to Conduct a Prior Authorization Please Attach a Copy of the Following:

☐ Recent Office Notes (along w/ any therapies tried and outcomes)
☐ Current Medication List
☐ History and Physical Report
☐ Demographic Sheet
☐ Insurance Cards (Front and Back)
☐ MRI Brain

Lab Result

☐ CMP (w/in past 3 months) ☐ CBC (w/in past 3 months) ☐ JCV Antibody (Tysabri pts only)