

**PATIENT INFORMATION**

 Patient Name: \_\_\_\_\_ Social Sec #: \_\_\_\_\_ Weight: \_\_\_\_ lbs  
 D.O.B: \_\_\_\_\_ Sex: Male \_\_\_\_ Female \_\_\_\_ Height: \_\_\_\_ lbs  
 Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

**INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK**
**MEDICAL INFORMATION**

Allergies: \_\_\_\_\_

 Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached  Last MRI documentation attached

 Patient's TOUCH authorization  Hepatitis B antigen and Hepatitis B Core total antibody required  
*(only for Tysabri orders) (only for Ocrevus orders)*

 Labs: Required labs to be drawn by:  Infusion Clinic  Referring Physician

Lab Orders: \_\_\_\_\_

**INFUSION ORDERS**
 Migraines  
 ICD-10 \_\_\_\_\_

**Pre-Medication**
 Zofram 4mg slow IVP  Zofran 8mg IVP  Pepcid IV 20mg IVP  Toradol 30mg IVP  
 Solu-Medrol 125 mg IVP  Reglan 10mg IV/100ml NS over 20 minutes

**Protocol:**
 Depacon  500mg  750mg in 250mL NS  
 Magnesium Sulfate 1gm IV in 250mL  
 DHE 45  0.5mg  1mg IV in 100mL NS *(must be premed for nausea)*  
 File this as a standing order for \_\_\_\_\_ months

 Multiple Sclerosis Exacerbation  
 ICD-10 \_\_\_\_\_

 Solu-Medrol 1gm IV daily x \_\_\_\_\_ days  
 Solu-Cortef 1gm IV daily x \_\_\_\_\_ days

 Multiple Sclerosis  
 ICD-10 \_\_\_\_\_

 Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH)  
 Pre-medication protocol: Tylenol 1000mg PO and Benadryl 25mg PO  
 Date of last interferon dose \_\_\_\_\_  
 Ocrevus  300mg IV at 0 and 2 weeks, then 600mg IV every 6 months  
 600mg IV every 6 months  
 Pre-medication protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion.  
 Date of last interferon dose \_\_\_\_\_  
**Hypersensitivity/Anaphylaxis Response Protocol PRN**
**IVIG ORDERS**

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_ IVIG Brand: \_\_\_\_\_

IVIG Orders: \_\_\_\_\_ mg/kg or \_\_\_\_\_ gm/kg IV divided over \_\_\_\_\_ day (s)

**Protocol Pre-Medication Orders: Tylenol 1000mg PO**

Frequency: Every \_\_\_\_\_ weeks or \_\_\_\_\_ one time dose

 please choose one antihistamine:  Cetrizine 10mg PO  Diphenhydramine 25mg PO  Loratadine 10mg PO

 Additional Pre-Medication Orders:  Solu-Medrol \_\_\_\_\_ mg IVP

**PHYSICIAN INFORMATION**
*By signing this form and utilizing your services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.*

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_