

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ Ship To: <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Infusion Site Infusion Site Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Clinical Information (Please fax all pertinent clinical and lab information)			
<b>Diagnosis:</b> G35 (Multiple Sclerosis) _____ Diagnosis Date: _____ Type: Clinically isolated syndrome Relapsing-remitting Secondary-progressive Primary-progressive Progressive-relapsing Hepatic Impairment present: Yes No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____ Pre-existing hepatic conditions: HBV HCV _____ HBV Test: HBsAg+ HBcAb+ Both Negative Test date: _____ Has patient received an MS infusion product previously? Yes No If yes, product information: _____ Date of last infusion: _____ Date of next infusion: _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	Reason for Discontinuation of Therapy _____ _____	Approximate Start Date _____ _____	Approximate End Date _____ _____

Comorbidities: \_\_\_\_\_  
 Concomitant Medications: \_\_\_\_\_  
 Allergies:  NKDA  Other: \_\_\_\_\_


Prescription			
<b>Lemtrada®</b> (alemtuzumab)	<input type="checkbox"/> Infuse 12mg in 100ml NS IV daily over approx 4 hours for 5 consecutive days (total 60mg)  <input type="checkbox"/> Infuse 12mg in 100ml NS IV daily over approx 4 hours for 3 consecutive days (total 60mg) **Each treatment cycle will begin 12 months from 1st day of prior cycle**	Dispense: #5 - 12mg vials  Dispense: #3 - 12mg vials	Refills: 0  Refills: 0
<b>Ocrevus™</b> (ocrelizumab)	To order Ocrevus, see Ocrevus referral form		
<b>Tysabri®</b> (natalizumab)	To order Tysabri, fill out Touch form and fax to CoxHealth at Home		

For patients requiring immune globulin therapy, please fill out the respective form: [IVlg](#) or [SCIg](#).  
 Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: \_\_\_\_\_

*Stamp signature not allowed, physician signature required.*

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize CoxHealth at Home, and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.



Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1 855-419-4663 to obtain instructions as to the proper destruction of the transmitted material. Thank you.