Phone: 801-408-5700
Fax: 801-408-5763

ROCKY MOUNTAIN
Multiple Sclerosis Clinic

370 East 9th Ave Ste 208
Salt Lake City, UT 84103

INFUSION REFERRAL ORDER FORM

Patient Information

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

Provider Information

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

Insurance Information (please attach cards)

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

MEDICATION ORDER

Medication:

- ☐ Tysabri
- ☐ Ocrevus
- ☐ Other: _____

Dosing:

- ☐ 300mg
- ☐ 300mg ☐ 600mg

Frequency:

- ☐ Q28days ☐ Q_____days ☐ Other _____
- ☐ Q2weeks ☐ Q6months ☐ Other _____

Indication/Diagnosis:*

- ☐ (G35) Multiple Sclerosis
- ☐ Other: _____

***ICD-10 (required):** _____

Notes (Additional Info)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

Please Attach the Following Documents:

- ☐ Recent Office Notes (along w/ any therapies tried and outcomes)
- ☐ Current Medication List
- ☐ History and Physical Report
- ☐ Lab Results:
  - ☐ CMP (w/in past 3 months)
  - ☐ CBC (w/in past 3 months)
  - ☐ JCV Antibody (Tysabri pts only)
  - ☐ Hepatitis B (Ocre pts only)
- ☐ Insurance Cards (Front and Back):
- ☐ Demographic Sheet