

**Ocrevus Enrollment Form**

**TwelveStone Health Partners**

Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**Fax Referral To:**  
**(800) 223-4063**  
 Direct Phone: (615) 278-3350  
 Toll Free: (844) 893-0012



**PREVIOUS ADMINISTRATION**

<b>If YES, please provide the following information:</b>	<b>If NO, please indicate desired location for first dose:</b>
Last Infusion Date: _____	<input type="checkbox"/> Physician's Office TwelveStone Infusion Center: <input type="checkbox"/> Canton <input type="checkbox"/> Chattanooga <input type="checkbox"/> Knoxville <input type="checkbox"/> Mount Juliet <input type="checkbox"/> Murfreesboro <input type="checkbox"/> Other: _____ Desired Start Date: _____
Next Infusion Date: _____	

**DIAGNOSIS**

<b>Description</b>	<b>ICD-10 Code</b>
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> G35

**OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)**

<input type="checkbox"/> This signed order form	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Patient Demographics and Insurance Information	<input type="checkbox"/> Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

**CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)**

Patient Weight: \_\_\_\_\_ Kg    Height: \_\_\_\_\_ Inches/CM    BSA : \_\_\_\_\_    Allergies: \_\_\_\_\_

Line Access:     PIV     PICC (SL DL TL)     PORT (Huber size \_\_\_\_\_ Gauge \_\_\_\_\_ Length)     Sub-Q

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
<input type="checkbox"/> Ocrevus	<input type="checkbox"/> <b>Initiation</b> - Infuse 2 doses (separated by 2 weeks) of 300mg IV over a minimum of 2.5 hours; Observe patient on site for at least 1 hour after completion of each infusion.  <input type="checkbox"/> <b>Subsequent Doses</b> (6 months after 1st dose of Initiation) - Infuse 600mg IV over a minimum of 3.5 hours every 6 months; Observe patient on site for at least 1 hour after completion of each infusion.		<input type="checkbox"/> Hepatitis Panel  <input type="checkbox"/> CBC w/Differential

**LAB ORDERS - To be drawn by TwelveStone**

<u>Order</u>	<u>Frequency</u>
CBC w/Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
BMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____

**PRE-MEDICATIONS - \*RECOMMENDED/For No Pre-med Orders please check here**

<u>Oral</u>	<u>IV</u>
*Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
*Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	*Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratidine: <input type="checkbox"/> 10mg	
Ondansetron: <input type="checkbox"/> 4mg	

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

Physician's Phone # _____	Physician's NPI# _____	Physician's Fax # _____	Physician's Address _____
Dispense as Written _____	Date _____	Substitution Allowed _____	Date _____

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