TwelveStone Health Partners

Fax Referral To:
(800) 223-4063

Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

OCREVUS ORDER FORM

Date:	ICD-10 Code: ______________________________
Patient Name:	Allergies: _________________________________
Date of Birth:	Weight: _________lbs OR _____________kg

Therapy Status	Provider Information
New Start ☐ Continuing Therapy: Last Dose: _____________________	Ordering Provider: __________________________ Provider NPI: ______________________________ Provider Phone: ____________________________ Provider Fax: ______________________________ Provider Address: __________________________

MEDICATION ORDER

☐ Ocrevus	☐ Initiation: Infuse 2 doses of Ocrevus 300mg IV per protocol on Day 1 and Day 15. ☐ Maintenance: Infuse Ocrevus 600mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase. ✓ Pre-medications will be given as indicated below unless otherwise specified. Antihistamine dosage and route to be determined by on site provider.	***Refills x one year from date of signature unless indicated below.*** ☐ _______ Refills	***Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:*** *✓ Hepatitis B Surface Antigen* *✓ Hepatitis B Core Antibody* *✓ Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)*

PRE-MEDICATIONS

Oral	IV
✓ Acetaminophen: ___325mg ___500mg ☒ 650mg ☐ Loratadine: 10 mg ☐ Cetirizine: 10mg ✓ Diphenhydramine: ___25mg ___50mg ☐ Famotidine: ___20mg ___40mg ☐ Ibuprofen: ___200mg ___400mg ___600mg ☐ Ondansetron: ___4mg ___8mg ☐ Other___________________________	☐ Dexamethasone: ___4mg ___8mg ✓ Diphenhydramine: ___25mg __50mg ☐ Famotidine: ___20mg ___40mg ✓ Methylprednisolone 125mg ☐ Hydrocortisone 100mg ☐ Ondansetron: ___4mg ___8mg ☐ Other_________________________

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
   Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

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

Dispense as Written:	Substitution Allowed:
____________________ ________ Prescriber Name Date	____________________ ________ Prescriber Name Date