TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

OCREVUS ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

☐ Ocrevus

☐ Initiation: Infuse 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.
✓ Hebatitis B Core Antibody Total (Not Core IgM).
✓ Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)

PRE-MEDICATIONS

To be given 30-60 minutes prior to infusion

Oral

✓ Acetaminophen: _____ 325mg _____ 500mg __X__ 650mg
☐ Loratadine: _____ 10mg
☐ Cetirizine: _____ 10mg
✓ Diphenhydramine: _____ 25mg _____ 50mg
☐ Famotidine: _____ 20mg _____ 40mg
☐ Ibuprofen: _____ 200mg _____ 400mg _____ 600mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

IV

☐ Dexamethasone: _____ 4mg _____ 8mg
✓ Diphenhydramine: _____ 25mg _____ 50mg
☐ Famotidine: _____ 20mg _____ 40mg
✓ Methylprednisolone: __X__ 125mg
☐ Hydrocortisone: _____ 100mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(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 the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

V 4.13.23