TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

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

☐ New Start

☐ Continuing Therapy:
Last Dose: ______________________

PROVIDER INFORMATION

Ordering Provider: ______________________ Provider Fax: ______________________

Provider NPI: ______________________ Provider Address: ______________________

Provider Phone: ______________________

MEDICATION ORDER

Ocrevus

☐ Initiation: Infuse Ocrevus 300mg IV per protocol on Day 1 and Day 15.

☐ Maintenancee: 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.

✓ If no history of infusion reaction with any Orevus infusion, maintenance doses may be infused using titrated rates over two hours.

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 Total (Not Core IgM)

✓ Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)

PRE-MEDICATIONS

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

(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 11.22.23

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