

# TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



## OCREVUS ORDER FORM

Patient Name: _____	ICD-10 Code: _____	<b>Therapy Status</b>  <input type="checkbox"/> New Start  <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Date of Birth: _____	Allergies: _____	
Weight: _____ lbs OR _____ kg		

### PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

### MEDICATION ORDER

<b>Ocrevus</b>	<input type="checkbox"/> Initiation: Infuse Ocrevus 300mg IV per protocol on Day 1 and Day 15.  <input type="checkbox"/> Maintenance: Infuse Ocrevus 600mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase.  <input checked="" type="checkbox"/> Pre-medications will be given as indicated below unless otherwise specified. Antihistamine dosage and route to be determined by on site provider.  <input checked="" type="checkbox"/> If no history of infusion reaction with any Ocrevus infusion, maintenance doses may be infused using titrated rates over two hours.	Refills for one year from date of signature unless indicated below.  _____ Refills	<p style="text-align: center;"><b>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</b></p> <input checked="" type="checkbox"/> Hepatitis B Surface Antigen <input checked="" type="checkbox"/> Hepatitis B Core Antibody Total (Not Core IgM) <input checked="" type="checkbox"/> Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment) <input checked="" type="checkbox"/> Baseline LFT's
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### PRE-MEDICATIONS

<p><b>Oral</b></p> <input checked="" type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg <input checked="" type="checkbox"/> 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p><b>IV</b></p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input checked="" type="checkbox"/> Methylprednisolone: <input checked="" type="checkbox"/> 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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### 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)  <ul style="list-style-type: none"> <li>• History &amp; Physical, Last Office Visit Note</li> <li>• Patient Demographics and Insurance Information</li> <li>• Medication List</li> <li>• Recent Lab Work</li> </ul>
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**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

Prescriber Signature _____	Date _____
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