

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com

**OCREVUS ORDER FORM**

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

PROVIDER INFORMATION

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

MEDICATION ORDER

Ocrevus	<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;">Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</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

Oral <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: _____	IV <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"> History & Physical, Last Office Visit Note Patient Demographics and Insurance Information Medication List Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written: _____ Prescriber Signature _____ Date _____	Substitution Allowed: _____ Prescriber Signature _____ Date _____
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