OKLAHOMA INFUSION SERVICES

Ocrevus Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ G35 Multiple Sclerosis
Type: ☐ Relapsing-Remitting ☐ Primary-Progressive ☐ Secondary-Progressive ☐ Progressive-Relapsing
☐ Other: Code: ___________ Description: ____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: ___________ lbs / ___________ kg
☐ Patient Height: ___________ in / ___________ cm
☐ Allergies: ____
☐ Therapies Tried and Failed: ____
☐ Hepatitis B Screening (HBsAg): Date: ___________ Results: ________________
☐ Hepatitis B Screening (HBsAB): Date: ___________ Results: ________________
☐ Hepatitis B Screening (HBcAB): Date: ___________ Results: ________________
☐ Does patient have history of life threatening reaction to Ocrevus? ☐ Yes ☐ No

Last Brain MRI:
Date: ________________________

Date and Dose of Last:
☐ Avonex: ____________________
☐ Betaseron: ____________________
☐ Lemtrada: ____________________
☐ Ocrevus: ____________________
☐ Rebif: ____________________
☐ Tysabri: ____________________

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB
☐ Other ________________________________

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Ocrevus
☐ Initial Dose: 300mg weeks 0, 2
☐ Maintenance Dose: 600mg every 6 months after week 2

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP
☒ Tylenol tablet 500-1000mg PO PRN
☒ Benadryl 25mg PO PRN
☐ Other: ____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: ____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

______________________________________ ______________________
Prescriber's Signature: **Date:**

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.