

Please fax form to: 405-726-9849

Patient Information			
Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

Additional Information Needed		
<input type="checkbox"/> Fax front/back of insurance card	<input type="checkbox"/> Fax clinical/progress notes	<input type="checkbox"/> Fax labs
<input type="checkbox"/> Fax patient demographics	<input type="checkbox"/> Fax current medication list	<input type="checkbox"/> 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: _____

<p>Clinical Information:</p> <input type="checkbox"/> New Therapy Induction <input type="checkbox"/> Therapy Change <input type="checkbox"/> Therapy Continuation <input type="checkbox"/> Patient Weight: _____ lbs / _____ kg <input type="checkbox"/> Patient Height: _____ in / _____ cm <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Therapies Tried and Failed: _____ <input type="checkbox"/> Hepatitis B Screening (HBsAg): Date: _____ Results: _____ <input type="checkbox"/> Hepatitis B Screening (HBsAB): Date: _____ Results: _____ <input type="checkbox"/> Hepatitis B Screening (HBcAB): Date: _____ Results: _____ <input type="checkbox"/> Does patient have history of life threatening reaction to Ocrevus? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Last Brain MRI: Date: _____</p> <p>Date and Dose of Last:</p> <input type="checkbox"/> Avonex: _____ <input type="checkbox"/> Betaseron: _____ <input type="checkbox"/> Lemtrada: _____ <input type="checkbox"/> Ocrevus: _____ <input type="checkbox"/> Rebif: _____ <input type="checkbox"/> Tysabri: _____
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Lab Orders	Lab Orders to be done by
<input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> ESR <input type="checkbox"/> CRP <input type="checkbox"/> HBsAg <input type="checkbox"/> HBsAB <input type="checkbox"/> HBcAB <input type="checkbox"/> Other: _____	<input type="checkbox"/> Oklahoma Infusion Services <input type="checkbox"/> Referring Provider

Prescription Information	
<input type="checkbox"/> Ocrevus	<input type="checkbox"/> Initial Dose: 300mg weeks 0, 2 <input type="checkbox"/> Maintenance Dose: 600mg every 6 months after week 2

Pre-Medication Orders	
<input checked="" type="checkbox"/> Solu-Cortef 50-100mg SIVP <input checked="" type="checkbox"/> Tylenol tablet 500-1000mg PO PRN	<input checked="" type="checkbox"/> Benadryl 25mg PO PRN <input type="checkbox"/> Other: _____

Standing Orders for Adverse Reactions	
<input checked="" type="checkbox"/> Stop infusion and initiate NS bolus <input checked="" type="checkbox"/> Notify supervising physician and ordering provider <input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction <input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation	<input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis <input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula <input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness <input type="checkbox"/> 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.