



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION			
<input type="checkbox"/> G35.A Relapsing-remitting multiple sclerosis	<input type="checkbox"/> G35.B0 Primary progressive multiple sclerosis, unspecified	<input type="checkbox"/> G35.B1 Active primary progressive multiple sclerosis	<input type="checkbox"/> G35.B2 Non-active primary progressive multiple sclerosis
<input type="checkbox"/> G35.C0 Secondary progressive multiple sclerosis, unspecified	<input type="checkbox"/> G35.C1 Active secondary progressive multiple sclerosis	<input type="checkbox"/> G35.CD Non-active secondary progressive multiple sclerosis	<input type="checkbox"/> G35.D Multiple sclerosis, unspecified
<input type="checkbox"/> Other (Specify ICD-10 Code): _____			
Has Patient Completed the First 2 Loading Doses of Ocrevus®? <input type="checkbox"/> Yes <input type="checkbox"/> No Expected Date of First/Next Infusion: _____			
Date of Last MRI: _____ Past DMT Therapies: _____			
Hepatitis B (HBsAg and anti-HBV) Test Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Quantitative Serum Immunoglobulins Test Results: _____			
<input type="checkbox"/> Please Check to Confirm Understanding: According to immunization guidelines, live or live-attenuated vaccines should be administered at least 4 weeks prior to initiation of OCREVUS® and, whenever possible, for non-live vaccines at least 2 weeks prior to initiation of OCREVUS®.			

OCREVUS® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose	Administration	Refills
<input type="checkbox"/> Ocrevus® (ocrelizumab)	<input type="checkbox"/> 300 mg/10 mL (30 mg/mL) single-dose vial	<input type="checkbox"/> Initial Dose: 300 mg dose administered as 2 separate intravenous infusions 2 weeks apart. <input type="checkbox"/> Maintenance Dose: 600 mg dose administered once every 24 weeks; 2 infusion options to choose from: <input type="checkbox"/> Option 1: Single infusion administered over approximately 3.5 to 4 hours. <input type="checkbox"/> Option 2: Single infusion administered over approximately 2 hours (for eligible patients who have not experienced a serious infusion reaction with any previous OCREVUS infusion)	_____
Pre-Medication		Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen		<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine		<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone		<input type="checkbox"/> 40mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> _____		_____	_____

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INFUSION REACTION ORDERS

Mild reaction protocol:

Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

Acetaminophen 650mg PO, one time, for pyrexia or rigors

Diphenhydramine 50mg IV, one time, for pruritus or urticaria

Famotidine 20mg IV, one time, for, for pruritus or urticaria

Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:

0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:

Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

PICC:

Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:

Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____

Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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