



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 Multiple Sclerosis <input type="checkbox"/> Relapsing Forms of MD (RMS) <input type="checkbox"/> Primary Progressive MS (PPMS) <input type="checkbox"/> Other Diagnosis Code: _____	
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: _____
Date of last treatment with an OCREVUS product (if applicable) (MM/DD/YYYY): _____/_____/_____	

ORDERS	
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy	Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Quantity/Refills
<input type="checkbox"/> OCREVUS ZUNOVO™ (920mg/23mL)	<input type="checkbox"/> 920 mg/23,000 units (920 mg ocrelizumab and 23,000 units of hyaluronidase) administered as a single 23 mL subcutaneous injection in the abdomen over approximately 10 minutes every 6 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> Quantity: 1 Vial Refills: _____
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"/> Cetirizine	<input type="checkbox"/> 10mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> 20mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> _____	_____	_____

INFUSION REACTION ORDERS
Mild reaction protocol: <input checked="" type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus. <i>If symptoms worsen, see orders for moderate to severe reactions.</i>
Moderate reaction protocol: <input checked="" type="checkbox"/> Acetaminophen 650mg PO, one time, for pyrexia or rigors <input checked="" type="checkbox"/> Diphenhydramine 50mg IV, one time, for pruritus or urticaria <input checked="" type="checkbox"/> Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms <i>If symptoms worsen, see interventions for severe reactions</i>

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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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