TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

OCREVUS®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ G35 Multiple Sclerosis ☐ Other Diagnosis/ICD-10 Code: _____

Has Patient Completed the First 2 Loading Doses of Ocrevus®? ☐ Yes ☐ No Expected Date of First/Next Infusion: _____

Date of Last MRI: _____ Past DMT Therapies: _____

Hepatitis B (HBsAg and anti-HBV) Test Results: ☐ Positive ☐ Negative Quantitative Serum Immunoglobulins Test Results: _____

☐ **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	Dosing/Administration	Refills
☐ Ocrevus® (ocrelizumab)	☐ Initial Dose: 600 mg dose administered as 2 separate intravenous infusions 2 weeks apart. ☐ Maintenance Dose: 600 mg dose administered once every 24 weeks; 2 infusion options to choose from: ☐ Option 1: Single infusion administered over approximately 3.5 to 4 hours. ☐ 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	Directions
☐ Methylprednisolone	100 mg administered intravenously approximately 30 minutes prior to each OCREVUS infusion.
☐ Diphenhydramine	PO ☐ 25mg ☐ 50mg ☐ _____mg
☐ Acetaminophen	PO ☐ 325mg ☐ 650mg ☐ _____mg
☐ _____	_____

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_____ Date: _____

Prescriber Signature

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.