



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

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
<input type="checkbox"/> Ocrevus® (ocrelizumab)	<input type="checkbox"/> Initial Dose: 600 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	Directions	
<input type="checkbox"/> Methylprednisolone	100 mg administered intravenously approximately 30 minutes prior to each OCREVUS infusion.	
<input type="checkbox"/> Diphenhydramine	PO <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> _____mg	
<input type="checkbox"/> Acetaminophen	PO <input type="checkbox"/> 325mg <input type="checkbox"/> 650mg <input type="checkbox"/> _____mg	
<input type="checkbox"/> _____	_____	

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.

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