



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		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			
<input type="checkbox"/> G35 Multiple Sclerosis <input type="checkbox"/> Other Diagnosis/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®. ** Obtain the following labs at prior to start of treatment and at _____ frequency <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
OCREVUS® 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	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: 600 mg dose administered as 2 separate intravenous infusions 2 weeks apart. <input type="checkbox"/> Maintenance Dose: 600 mg dose administered once every 6 months; 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)	_____
Special Instructions: _____			
Pre- Medication		Route	Dose
<input type="checkbox"/> Acetaminophen		<input type="checkbox"/> PO	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)		<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____mg
<input type="checkbox"/> Diphenhydramine (Benadryl)		<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
<input type="checkbox"/> Other: _____		_____	_____

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**ANAPHYLACTIC REACTION (AR):**

- ☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh \geq 66 lbs (\geq 30 kg); may repeat in 3-5 mins x 1 if necessary
- ☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary
- ☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
- ☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access
- ☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr
- ☐ Other: _____

SIGNATURE

We hereby authorize Valustar 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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