

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Gender: _____
 Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

Primary Diagnosis:

G35 Primary Progressive Multiple Sclerosis
 G35 Relapsing Remitting Multiple Sclerosis
 Other ICD-10: _____
 Number of Relapses the past year: _____
 Date of Diagnosis: _____

DIAGNOSIS/CLINICAL INFORMATION

Therapy: New Reauthorization Restart
 Date of last infusion with Ocrevus®: _____ Next dose due: _____
 Patient Weight: _____ kg lbs Height: _____ cm in
 Allergies: _____
 Concomitant Medications: _____
 Comorbidities: _____
 Hepatitis B virus screening (HBsAg and anti-HBV test) required:
 Negative
 Positive (Contraindicated)

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity/Refills:
<input type="checkbox"/> Ocrevus® (ocrelizumab) Initial Dose (two infusions)	300 mg per 10 mL SDV Vials are diluted in NS to a final concentration of 1.2 mg per mL	Infusion 1: 300 mg in 250 mL of 0.9% NS. Infusion 2 (2 weeks later): 300 mg in 250 mL of 0.9% NS. Start infusion at 30 mL per hour. Increase by 30 mL per hour every 30 minutes. Maximum: 180 mL per hour. Duration 2.5 hours or longer.	Dispense: <input type="checkbox"/> 1 month supply No refills
<input type="checkbox"/> Ocrevus® (ocrelizumab) Subsequent doses (one infusion)	300 mg per 10 mL SDV Vials are diluted in NS to a final concentration of 1.2 mg per mL	Every 6 months infuse 600 mg in 500 mL of 0.9% NS. Start infusion at 40 mL per hour. Increase by 40 mL per hour every 30 minutes. Maximum: 200 mL per hour. Duration 3.5 hours or longer.	Dispense: <input type="checkbox"/> 1 month supply Refills: <input type="checkbox"/> 1 <input type="checkbox"/> 0

PREMEDICATION ORDERS/OTHER MEDICATIONS

Premedications & Other Medications

Acetaminophen 650 mg PO 30 min prior to infusion Infusion supplies as per protocol
 Diphenhydramine 50 mg PO 30 min prior to infusion Anaphylaxis Kit orders as per protocol
 Methylprednisolone 100 mg IV 30 min prior to infusion
 Other: _____
 Labs to be drawn: _____ Frequency: _____

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X _____
 DISPENSE AS WRITTEN (Date)