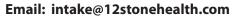
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





OCREVUS ORDER FORM						
Date:		ICD-10 Code:			Therapy Status	
Patient Name:		Allergies:			☐ New Start	
Date of Birth:		Weight:Ibs OR		kg	☐ Continuing Therapy:  Last Dose:	
PROVIDER INFORMATION						
Ordering		Provider Fax:				
Provider NPI:				Provider Address:		
	Phone:					
				N OPDEP		
MEDICATION ORDER  ☐ Initiation: Infuse Ocrevus 300mg IV per protocol on						
Ocrevus	Day 1 and Day 15.  Maintenancee: Infuse Ocrevus 600mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase.		x Ref date	Refills for one year from ate of signature unless indicated below. Refills		
			MEDI	CATIONS		
Oral         ✓ Acetaminophen:325mg500mgX650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         ✓ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:			IV     □     Dexamethasone:4mg8mg       ✓ Diphenhydramine:25mg50mg       □ Famotidine:20mg40mg       ✓ Methylprednisolone:X 125mg       □ Hydrocortisone: 100mg       □ Ondansetron:4mg8mg       □ Other:			
LAB ORDERS (please indicate any labs to be drawn and frequency)				OTHER REQUIRED DOCUMENTATION		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**				(Please fax this signed order form, along with the following documents to 800-223-4063)  • History & Physical, Last Office Visit Note  • Patient Demographics and Insurance Information  • Medication List  • Recent Lab Work		
By signing this	form, I am authorizing TwelveStone Hea	alth Partners and affiliates to se	rve as m	ny designated agent in	submitti	iber's Signature (SIGN BELOW) ing prior authorizations and other clinically required information ature for prior authorizations, as requested.
Dispense as Written:				Substitution Allowed:		
Prescriber N	ame	Date		Prescriber Nam	16	 Date