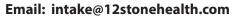
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





OCREVUS ORDER FORM						
Date:	ICD-10 Code:	CD-10 Code:		Therapy Status		
Patient Name:	Allergies:	Allergies:		☐ New Start		
Date of Birth: Weight:					Continuing Therapy:  Last Dose:	
PROVIDER INFORMATION						
Ordering Provider: Provider Fax:						
Provider	Provider Address:_	Provider Address:				
Provider Phone:						
MEDICATION ORDER						
INIEDIOATION ONDER						
Ocrevus ZUNOVO	<ul> <li>□ Administer 920mg subcutaneously in the abdomen over approximately 10 minutes every 6 months.</li> <li>✓ Pre-medications will be given as indicate below unless otherwise specified.</li> </ul>	imately 10 minutes  Refills for date of segiven as indicated		ess	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:   Hepatitis B Surface Antigen	
	✓ Initial Dose: Monitor for at least one hour post injection, for subsequent doses mor for 15 minutes.	nitor	Refills		<ul> <li>✓ Hepatitis B Core Antibody Total (Not Core IgM)</li> <li>✓ Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)</li> </ul>	
PRE-MEDICATIONS						
Oral         ✓ Acetaminophen:325mg500mgX650mg         ✓ Dexamthasone: 20mg         ✓ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:			□ Diphenhyd □ Famotidine □ Methylpred □ Hydrocortie □ Ondansetr	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg		
LAB ORDERS (please indicate any labs to be drawn and frequency)			ОТН	OTHER REQUIRED DOCUMENTATION		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**  By signing below, I certify that the above therapy is medi  By signing this form. I am authorizing TwelveStone Health Partners and affiliates to serve as m			to 800-223-4063         History & Phys         Patient Demog         Medication Lis         Recent Lab W  dically necessary. I	(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  ically necessary. Prescriber's Signature (SIGN BELOW)  by designated agent in submitting prior authorizations and other clinically required information		
Dispense as		my sigr wed:	nature for prior authorizations, as requested.			
L Proceriber N	ama Data		Lirocombor Niom		Data	