TEXAS CENTERS FOR TCIDA INFECTIOUS DISEASE ASSOCIATES

OCREVUS

☐ FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
☐ DALLAS / 3410 Worth St., Ste. 790, Dallas TX 75246

TEL: ***817-336-1640*** FAX: ***817-336-1643***

PATIENT INFORMATION:			**PRESCRIBER INFORMATION:**		
Patient Name:			Prescriber Name:		
Address 1:			DEA:		
Address 2:			NPI:	License:	
City:	State:	Zip:	Address:		
Home Phone:	Alt:		City:	State:	Zip:
DOB: SSN: Gender: ☐ Male ☐ Female			Phone:	Fax:	
Language: ☐ English ☐ Spanish ☐ Other			POC:	Email	

INSURANCE INFORMATION: (Complete entirely or fax front and back of patient's prescription card)

Prescription Card:	Name of Insurer:	ID#	BIN:	PCN:	GROUP:
Primary Insurance:	Subscriber:	ID#	Name of Insurer:	Phone:	
Secondary Insurance:	Subscriber:	ID#	Name of Insurer:	Phone:	

CLINICAL INFORMATION:	**PATIENT HISTORY:**
Diagnosis ☐ G35 Multiple Sclerosis **ICD-10 Code:** ☐ Other _____	Weight ☐ kg ☐ lb Height ☐ cm ☐ in
☐ Clinical/Progress notes, labs, tests supporting primary diagnosis attached	☐ NKDA ☐ Allergies
☐ Hepatitis B surface antigen and Hepatitis B core total antibody required prior to first dose__	
☐ Last MRI Report	Comorbidities:
Is patient currently taking any medications for MS that would need to be discontinued and what is washout time frame?: _____	Concurrent Meds:

PRESCRIPTION INFORMATION:

Medication	Dose	SIG		Refills
OCREVUS ORDERS:				
☐ OCREVUS™ ☐ OCREVUS™	☐ 300 mg ☐ 600 mg	☐ INDUCTION DOSE: 300 mg IV at 0 and 2 weeks, then 600mg IV every 6 months ☐ MAINTENANCE DOSE: 600 mg IV every 6 months		
Pre medication Orders:				
☐ Benadryl ☐ Solu-Medrol IV	☐ 25 mg ☐ 125 mg	☐ PO -- 60 minutes prior to infusion OR ☐ IV -- 30 minutes prior to infusion ☐ 30 minutes prior to infusion		

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber Signature: _____ Date: _____