



Ocrevus® Order

Phone: (346) 708-5160
Fax: (888) 963-8103

www.biotekrx.com

PATIENT INFORMATION (Complete or fax existing chart)		PRESCRIBER INFORMATION	
Patient Name:		Prescriber Name:	
Address:		State License:	NPI#:
City, State, Zip:		DEA:	Phone:
Phone:	2 nd Phone:	Address:	Fax:
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		City, State, Zip:
Weight:	Ht:	Allergies:	Contact Person:
Phone:		Plan#	Group#
INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)			
Primary Insurance:		RX Card (PBM):	
City, State, Zip:		BIN:	PCN:
Plan#	Group#	City, State, Zip:	
Phone:		Plan#	Group#
PREVIOUS THERAPIES			
<input type="checkbox"/> Rebif	<input type="checkbox"/> Avonex	<input type="checkbox"/> Betaseron	<input type="checkbox"/> Tysabri
<input type="checkbox"/> Ocrevus – Date of last infusion: _____			
LABS			
Lab Tests		Directions	
<input type="checkbox"/> Hepatitis B Screening Complete		<input type="checkbox"/> Yes – Results Attached <input type="checkbox"/> No- In Process	
<input type="checkbox"/> Quantitative Immunoglobulin		<input type="checkbox"/> Yes – Results Attached <input type="checkbox"/> No- In Process	
PREMEDICATION			
Standard Protocol		Additional	
<input type="checkbox"/> Acetaminophen 500 mg		<input type="checkbox"/> Acetaminophen 1000 mg	
<input type="checkbox"/> Diphenhydramine PO or IV 25 mg		<input type="checkbox"/> Zyrtec 10 mg PO	
<input type="checkbox"/> Solu-Medrol 125 mg SIVP		<input type="checkbox"/> Famotidine 20mg IV	
PRESCRIPTION / ADMINISTRATION			
Medication	Dose	Directions	
Ocrevus	<input type="checkbox"/> 300 mg IV (Loading dose)	At 0 and 2 weeks	
	<input type="checkbox"/> 600 mg IV (Maintenance dose)	Every 6 months	
SIGNATURE			
x _____ Date: _____ (Product Substitution Permitted)			

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.

If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (888) 963-8103 - Thank you for using BioTek reMEDys®