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:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ Female		City, State, Zip:	
Weight:	Ht:	Allergies:	Contact Person:	Phone:

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			
☐ Rebif	☐ Avonex	☐ Betaseron	☐ Tysabri
☐ Ocrevus – Date of last infusion:			

LABS		
Lab Tests	Directions	
☐ Hepatitis B Screening Complete	☐ Yes – Results Attached	☐ No- In Process
☐ Quantitative Immunoglobulin	☐ Yes – Results Attached	☐ No- In Process

PREMEDICATION	
Standard Protocol	**Additional**
☐ Acetaminophen 500 mg	☐ Acetaminophen 1000 mg
☐ Diphenhydramine PO or IV 25 mg	☐ Zyrtec 10 mg PO
☐ Solu-Medrol 125 mg SIVP	☐ Famotidine 20mg IV

PRESCRIPTION / ADMINISTRATION			
Medication	**Dose**	**Directions**	
Ocrevus	☐ 300 mg IV (Loading dose)	At 0 and 2 weeks	
	☐ 600 mg IV (Maintenance dose)	Every 6 months	

SIGNATURE

x _____ Date: _____
(Product Substitution Permitted)

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