

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – OR – Send a copy of the patient’s prescription/insurance cards (front & back)			
Primary Insurance: _____ City, State, Zip: _____ Plan #: _____ Group #: _____ Phone: _____		RX Card (PBM): _____ BIN: _____ PCN: _____ City, State, Zip: _____ Group #: _____ Phone: _____	
CLINICAL INFORMATION			
Primary ICD-10 Code: _____		<input type="checkbox"/> Tried and failed medications:	
<input type="checkbox"/> Hep B panel:		<input type="checkbox"/> Concurrent Meds:	
<input type="checkbox"/> Quantitative Immunoglobulin		<input type="checkbox"/> NKDA <input type="checkbox"/> Known drug allergies	
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Expected date of first/next injection: _____ Date of last injection (if relevant): _____	
Agency nurse to visit home for injection: <input type="checkbox"/> Yes <input type="checkbox"/> No		Agency name and telephone: _____	
(DRUG NAME) ORDERS – this section may not be needed			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Infusion/Injection: _____			
Medication	Directions	Quantity/Refills	
<input type="checkbox"/> Kesimpta® (ofatumumab) 20mg (0.4mL) <input type="checkbox"/> Prefilled syringes <input type="checkbox"/> Sensoready pens	<input type="checkbox"/> Loading dose: Inject 1 unit (0.4mL) subcutaneously at week 0, 1 and 2. <input type="checkbox"/> Maintenance dose: Inject 1 unit (0.4mL) each month.	Supply: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Other ___ Refills ___	
Pre-medication: _____			
SIGNATURE			
X _____ Prescriber Signature		Date: _____	

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