



Ocrevus® Order

Phone:
(877)-246-9104 Fax:
(800) 783-9146

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	Refills
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)			

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