

PATIENT INFORMATION
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Patient Name: _____

 DOB: _____ Gender: ☐ Male ☐ Female

Address: _____

City _____ State _____ Zip: _____

Primary Phone: _____ SSN: _____

Caregiver Name: _____

Alternate Phone: _____

PRESCRIBER INFORMATION
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Prescriber Name: _____

State License #: _____ DEA #: _____

NPI #: _____

Address: _____

City _____ State _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

Please fax a copy of front and back of the insurance card(s).
Clinical Information (Please fax pertinent lab information)

 Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ Other (ICD-10 code with description): _____ Diagnosis Date: __/__/____

 Type: ☐ Primary-progressive ☐ Secondary-progressive ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Progressive-relapsing

 Has pregnancy been excluded: ☐ Yes ☐ No ☐ Not Applicable

 Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in

 Hepatic impairment present: ☐ Yes ☐ No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____

 Prior Therapy ☐ Yes ☐ No

Reason for Discontinuation of therapy

Start date

End Date

 Allergies: ☐ NKDA ☐ Other: _____

Comorbidities: _____

Concomitant Medications: _____

Drug
Dose/Strength
Directions
Qty
Refills
LEMTRADA
 (alemtuzumab)

OCREVUS
 (ocrelizumab)

300mg/10mL Vial

Starter Dose:

Infuse 300 mg intravenously over no less than 2.5 hours on day 1 and day 15.

Maintenance Dose:

Infuse 600 mg intravenously over no less than 3.5 hours every 6 months.

Premedication:

Methylprednisolone

Other: _____

Other: _____

Infuse 100 mg IV approximately 30 mins prior to Ocrevus

Other: _____

Premedication

Diphenhydramine

Other: _____

Other: _____

Other: _____

☐ Product substitution permitted

☐ Dispense as written

Prescriber's Signature: _____ Date: _____