

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____
Please fax a copy of front and back of the insurance card(s).	

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: G35 (Multiple Sclerosis) _____		Diagnosis Date: _____	
Type: Clinically isolated syndrome Relapsing-remitting Secondary-progressive Primary-progressive Progressive-relapsing			
Hepatic Impairment present: Yes No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____			
Pre-existing hepatic conditions: HBV HCV _____ HBV Test: HBsAg+ HBcAb+ Both Negative Test date: _____			
Has patient received an MS infusion product previously? Yes No			
If yes, product information: _____ Date of last infusion: _____ Date of next infusion: _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	Reason for Discontinuation of Therapy _____ _____	Approximate Start Date _____ _____	Approximate End Date _____ _____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	
Flushing Orders: • Per HPS protocol PIV: 0.9% Sodium Chloride 3-20 ml before and after infusion as needed Port: Bacteriostatic 0.9% Sodium Chloride 3-20ml into port at time of access or at least monthly, 0.9% Sodium Chloride 3-20 ml before and after infusion and as needed, Heparin 100units/ml 5ml as lock after infusion Pre-Medication Orders: <input type="checkbox"/> Diphenhydramine _____ mg PO 15-30 minutes prior to infusion <input type="checkbox"/> Diphenhydramine _____ mg IV in 10ml NS 15-30 minutes prior to infusion <input type="checkbox"/> Methylprednisolone _____ mg IV in NS 15-30 minutes prior to infusion <input type="checkbox"/> Other: _____	Ocrevus (ocrelizumab): Dose/Freq: <input type="checkbox"/> Ocrevus 300mg IV on day 1 and day 15, then 600mg every 6 months, starting 6 months from day 1. OR <input type="checkbox"/> Ocrevus 600mg IV every 6 months •Rate per manufacturers protocol •Dilute 300mg in 250ml NS and 600mg in 500ml NS Duration: Refills x 1 year OR _____ infusions Note: • Orders are initiated unless crossed out by provider

Prescriber's Signature: _____	<input type="checkbox"/> Substitution Permitted <input type="checkbox"/> Dispense as Written	Date: _____
I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.		

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1-800-637-9201 to obtain instructions as to the proper destruction of the transmitted material. Thank you.