

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: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____

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: NKDA Other: _____

Prescription

<p>Flushing Orders: • Per CoxHealth at Home 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</p> <p>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: _____</p>	<p>Ocrevus (ocrelizumab):</p> <p>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</p> <p>•Rate per manufacturers protocol •Dilute 300mg in 250ml NS and 600mg in 500ml NS</p> <p>Duration: Refills x 1 year OR _____ infusions</p> <p>Note: • Orders are initiated unless crossed out by provider</p>
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Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home 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 CoxHealth at Home



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