AYSA
THERAPEUTICS INFUSION

OCREVUS ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: ____________ Phone: ________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Multiple Sclerosis (ICD-10 Code: __________)

☐ Relapsing-Remitting ☐ Primary-Progressive

☐ Secondary-Progressive ☐ Progressive-Relapsing

Patient Weight: __________ lbs.

Allergies: ____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ Hepatitis B surface antigen and Hepatitis B Core total antibody required

☐ Last MRI

Labs: Required labs to be drawn be: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

OCREVUS ORDERS

Ocrevus ☐ **Loading Dose:** 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months

☐ **Subsequent Dose:** 600mg IV every 6 months

Protocol Pre-Medication Orders: Solu-medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion

****Date of last** ☐ Rebif ☐ Betaseron ☐ Avonex ☐ Tysabri dose: ____________________

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ____________________ Physician Name: ____________________ Date: __________

Phone: ____________________ Fax: ____________________ Contact Person: ____________________

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