

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 F (832) 500-8629 E specialty@hqrx.com

LAST TREATMENT DATE: _____ NEXT DUE DATE: _____

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name _____	Prescriber's Name _____
Patient Address _____	DEA # _____ NPI # _____
City _____ State _____ Zip _____	Practice Name _____
Day Phone _____ Work Phone # _____	Office Contact _____
Cell Phone _____	Address _____ Suite # _____
Date of Birth _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	City _____ State _____ Zip _____
E-mail _____	Phone _____ Fax _____

DIAGNOSIS

Patient: Wt. _____ Ht. _____ Allergies: Latex Other, specify _____
 Diagnosis: _____ (ICD-10 Code: _____)

PRESCRIPTION

MEDICATION	INFUSION ORDERS	REFILLS
Ocrevus (ocrelizumab)	<input type="checkbox"/> 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months <input type="checkbox"/> 600mg IV every 6 months <u>Pre-medication Orders:</u> Solu-Medrol 100mg IV and diphenhydramine 25mg PO 30 minutes before infusion (if no contraindications) Substitute diphenhydramine with: <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Cetirizine 10mg IV	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
Ocrevus Zunovo (ocrelizumab/ hyaluronidase)	<input type="checkbox"/> 920mg/23,000units subcutaneously every 6 months <u>Pre-medication Orders:</u> dexamethasone 20mg PO and cetirizine 10mg PO 30 minutes before injection (if no contraindications)	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Premedication orders: to be administered 15–30 minutes before infusion

- Acetaminophen 500mg PO Normal Saline 500mL IV Cetirizine 10mg PO
 Solu-Medrol _____mg IVP Diphenhydramine 25mg PO Quztytir 10mg IVP
 Loratadine 10mg PO Diphenhydramine 25mg IV Other: _____

Lab orders: CBC CMP CRP Other: _____

Frequency: Every infusion Other: _____

Required labs to be drawn by: HealthQuest Referring physician

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
 - >30kg (>66lbs): Epinephrine 0.3mg IMPen or subQ; may repeat in 5–10 minutes x1
 - 15–30kg (33–66lbs): Epinephrine 0.15mg IM or subQ; may repeat in 5–10 minutes x1
- Diphenhydramine: Administer 25–50mg orally OR IV (adult)
- NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing and infusion reaction management

Flush orders: NS 1–10mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.

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PATIENT INFORMATION

Patient Name _____ Date of Birth _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include **signed** and **completed** order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to therapy
 - Expanded Disability Status Scale (EDSS) score: _____
- Include labs and/or test results to support diagnosis
 - MRI
- If applicable - Last known biological therapy: _____ and last date received: _____
If patient is switching biologic therapies, please perform a washout period of _____ weeks prior to starting ocrelizumab.

Other medical necessity: _____

REQUIRED PRE-SCREENING

- Hepatitis B screening test completed.
This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) patient - **attach results**
 - Positive Negative

** If Hepatitis B results are positive, please provide documentation of treatment or medical clearance*

- Liver function tests including bilirubin

HealthQuest Infusion & Specialty will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please **fax** all information to **(832) 500-8629**