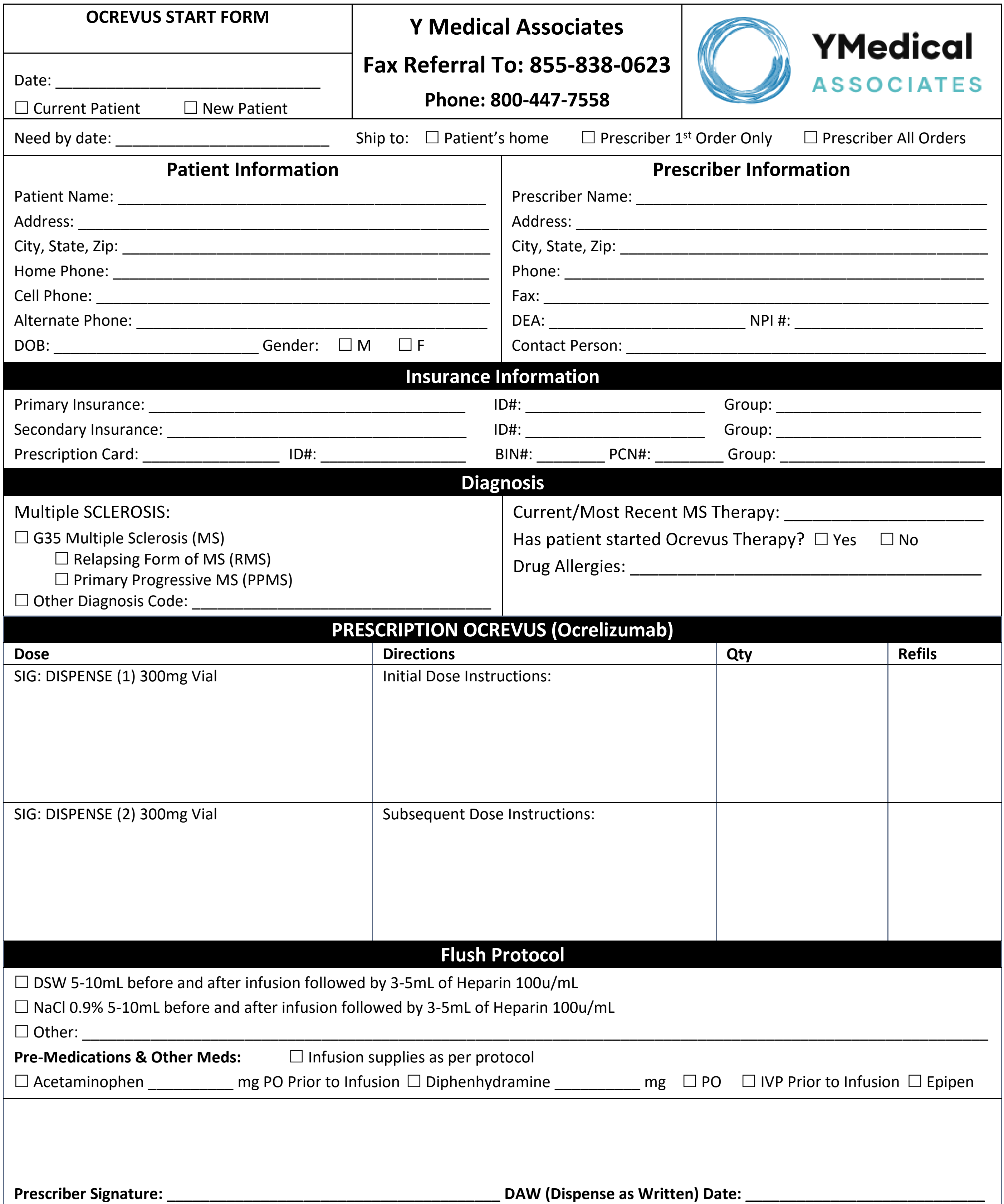

OCREVUS START FORM

Date: ______________________________

☐ Current Patient ☐ New Patient

Y Medical Associates

Fax Referral To: 855-838-0623

Phone: 800-447-7558

YMedical ASSOCIATES

Need by date: ________________________ Ship to: ☐ Patient's home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

Patient Information

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Alternate Phone: ______________________________

DOB: ______________________ Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________________________

Fax: ______________________________

DEA: ____________________ NPI #: ____________________

Contact Person: ______________________________

Insurance Information

Primary Insurance: ______________________ ID#: ________________ Group: ________________

Secondary Insurance: ______________________ ID#: ________________ Group: ________________

Prescription Card: ______________ ID#: ______________ BIN#: ________ PCN#: ________ Group: ________________

Diagnosis

Multiple SCLEROSIS:

☐ G35 Multiple Sclerosis (MS)

☐ Relapsing Form of MS (RMS)

☐ Primary Progressive MS (PPMS)

☐ Other Diagnosis Code: ______________________________

Current/Most Recent MS Therapy: ______________________

Has patient started Ocrevus Therapy? ☐ Yes ☐ No

Drug Allergies: ______________________________

PRESCRIPTION OCREVUS (Ocrelizumab)

Dose	Directions	Qty	Refills
SIG: DISPENSE (1) 300mg Vial	Initial Dose Instructions:		
SIG: DISPENSE (2) 300mg Vial	Subsequent Dose Instructions:		

Flush Protocol

☐ DSW 5-10mL before and after infusion followed by 3-5mL of Heparin 100u/mL

☐ NaCl 0.9% 5-10mL before and after infusion followed by 3-5mL of Heparin 100u/mL

☐ Other: ______________________________

Pre-Medications & Other Meds: ☐ Infusion supplies as per protocol

☐ Acetaminophen __________ mg PO Prior to Infusion ☐ Diphenhydramine __________ mg ☐ PO ☐ IVP Prior to Infusion ☐ Epipen

Prescriber Signature: ______________________________ **DAW (Dispense as Written) Date:** ______________________

If Y Medical is the patient's choice for Home or On-Site Infusion Services, please Call, Fax, Mail or send an Electronic Prescription to Y Medical 8840 N MacArthur Blvd Irving, TX 75063 ● Phone (800) 447-7558, Fax (855) 838-0623