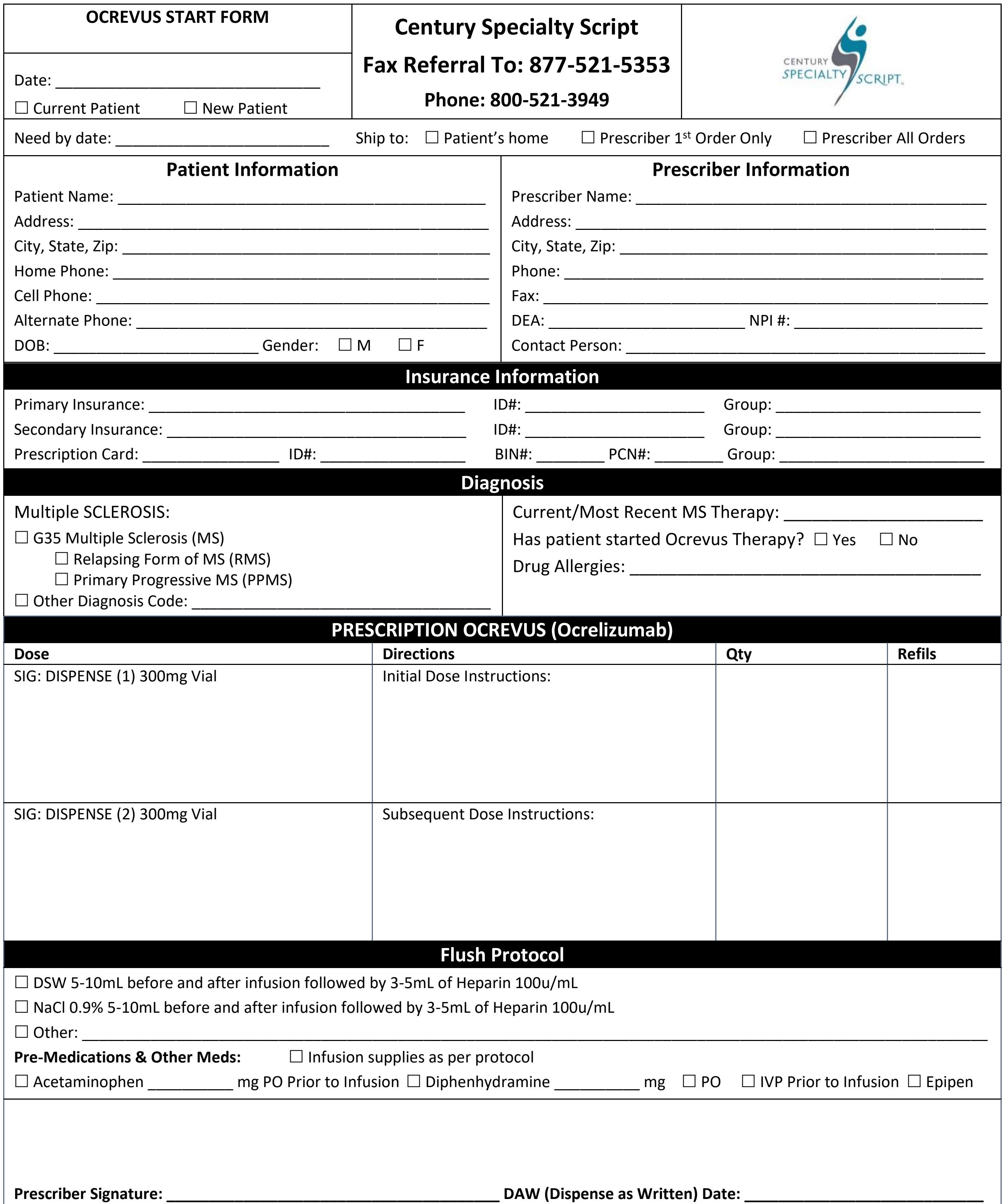

OCREVUS START FORM

Date: ____________________________

☐ Current Patient ☐ New Patient

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

CENTURY SPECIALTY SCRIPT

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	Refils
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 Century Specialty Script is the patient's choice, please Call-In, Fax or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353