Texas Centers for Infectious Disease Associates Pharmacy
FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
Phone: 817-336-1640 Fax: 817-336-1643
DALLAS / 3410 Worth St., Ste. 780, Dallas TX 75246

Patient Information	Prescriber Information
Patient name:	Prescriber name:
DOB: SSN:	DEA:
Address:	NPI License:
City: State: Zip:	Address:
Phone #:	City: State: Zip:
Gender: ☐Male ☐Female ☐Other	Phone: Fax:

Insurance Information: Complete entirely and fax front and back of patient's insurance card

Primary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Secondary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Prescription card:	Name of insurer:	ID:	BIN:	PCN:	Group:

ICD 10 and Diagnosis:	Patient History
ICD 10: ☐ G35 Multiple Sclerosis ☐ Other: _____ ☐ Clinical/progress notes, labs and test supporting diagnosis attached ☐ Hepatitis B surface antigen and Hepatitis B core total antibody required prior to first dose ☐ Last MRI report	Weight ☐KG ☐LB Height ☐IN ☐CM ☐NKDA ☐Allergies: _____ _____ _____

Provider Orders:

	Drug	Dose	Directions	Refills
MEDICATION	☐ Ocrevus	☐ 300mg ☐ 600mg	☐ Induction dose: 300mg IV at 0 and 2 weeks ☐ Maintenance dose: 600mg Iv every 6 months	
Pre-medication	☐ Diphenhydramine ☐ 25mg ☐ PO (60 mins prior to infusion) OR ☐ IV(30 mins prior to infusion X1 if needed) ☐ Solu-Medrol IV ☐ 125 mg ☐ 30 minutes prior to infusion			

LABS	
Baseline labs on admission and then drawn weekly while on therapy	☐CBC with differential ☐ CMP ☐ CRP Quant ☐ESR ☐CK ☐other: _____

Nursing: Evaluate and teach patient administration of IV medication, provide IV-line dressing change weekly and PRN, use SASH flushing protocol: S-Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration

Prescriber Authorization: I authorize this pharmacy and its representative to act as my agent to secure coverage, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.
Prescriber signature: _____ Date: _____