PUREONE INFUSION

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New Referral **Dose or Frequency Change** **Order Renewal**

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Allergies: _____ Weight:(lbs) _____ Height:_____

Phone: _____ Email: _____

ICD CODE/ICD DESCRIPTION

_____ _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider NPI: _____

Phone: _____ Fax: _____

Practice Site Name: _____

Practice Address: _____

REQUIRED DOCUMENTATION

- This order is signed by provider
- Patient's demographics AND insurance information
- Tried and failed therapies
- Clinical notes supporting primary diagnosis
- Labs and tests supporting primary diagnosis
- Pregnancy test (if applicable)
- Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM
- Anti-JCV antibodies test result (if applicable)

Has patient been enrolled in the Touch Program? ◯ Yes ◯ No ◯ N/A

MEDICATION ORDERS

Tysabri	◯ Infuse 300 mg IV every _____ weeks
Briumvi	◯ Initial dosing:Infuse 150 mg IV as directed day 1, then 450mg IV day 15 ◯ Maintenance dosing: Infuse 450 mg IV as directed every 24 weeks
Ocrevus	◯ Initial dosing:Infuse 300 mg IV as directed day 1, then day 15 ◯ Mainteanance dosing: Infuse 600 mg IV as directed every 6 months
Other	◯

Pre-Medications

◯ Acetaminophen: 650 mg PO, given 30-60 minutes prior to infusion
◯ Benadryl: 25 mg PO 50mg PO 25mg IV 50mg IV, given 30-60 minutes prior to infusion
◯ Methylprednisolone: 100mg IV slow push, 30 minutes prior to infusion

Refills: x6 months x1 year doses

***Order valid x1 year unless indicated**

Special Instructions

_____

_____ _____ ____ / ____ / ____

Provider Name Provider Signature Date