



Ocrevus (Ocrelizumab)

INFUSION THERAPY CENTERS

New Referral Restart Medication Order Change

PATIENT INFORMATION

Name _____
Date _____
DOB _____
SS# _____
Phone # _____
Email _____

PHYSICIAN INFORMATION

Referring Physician _____
Practice Address _____
Office Contact Name _____
Contact Phone # _____ Fax # _____
NPI / TIN _____

MEDICATION ORDERS

Patient Weight: _____ kg Initial/Reload Dosing: 300mg Day 0, 300mg Day 14
 Maintenance Dosing: 600mg every 6 months (*Observe for 1 hour post-infusion*)

Premeds: diphenhydramine APAP IV methylprednisolone 100mg

Indication / Diagnosis:

- G35 Relapsing Multiple Sclerosis
- Primary Multiple Sclerosis
- Other (*please specify in additional information*)

Additional Information:

ICD-10 (Required) _____

MD Signature _____ Date _____

REQUIRED DOCUMENTATION

Please send the following documents and records. This will help streamline the pre-authorization process.

- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- If this is a continuation of a treatment, include the last infusion note
- Current medication list

Most recent diagnostics results to include:

- MRI
- HBV surface antigen
- CBC
- Comprehensive metabolic panel

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

AZIVinfusion.com | CALL CENTER: 602.386.4968 | FAX: 623.594.8533

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Mesa, AZ 85210

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2001 W. Orange Grove Road, Suite
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