Ocrevus (Ocrelizumab)

☐ New Referral ☐ Restart ☐ Medication Order Change

PATIENT INFORMATION

Name ______________________

Date ______________________

DOB ______________________

SS# ______________________

Phone # ______________________

Email ______________________

PHYSICIAN INFORMATION

Referring Physician ______________________

Practice Address ______________________

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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)*

ICD-10 (Required) ______________________

MD Signature ______________________ Date ____________

Additional Information:

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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.