



Ocrevus (ocrelizumab)

New Referral Continue Treatment Order Change

Patient Information:

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

Physician Information:

Referring Physician: _____
 Address: _____

 Phone #: _____
 Fax #: _____

Medication Orders

Patient Weight: _____kg Patient Height: _____inches First Dose Maintenance Dose

Dosing: LOADING DOSES: 300mg IV Day 1 and 300mg IV Day 15 (1 hr observation period post infusion)
 MAINTENANCE DOSE: 600mg IV every 6 months (1 hr observation period post infusion)

Premeds: Benadryl 25mg IV Tylenol 1000mg PO Dexamethasone 20mg IV _____

Indication / Diagnosis:
 G35 Relapsing Multiple Sclerosis
 Other (please specify) _____
ICD-10 (Required) _____

MD Signature: _____ **NPI#:** _____ **Date:** _____

Required Documentation

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

- **If this is a continuation of a treatment, include the last infusion note**
- 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)
- Current medication list

Most recent diagnostics results to include:

- Most recent MRI (head/brain)
- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb (SURFACE ANTIGEN HBV)

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

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