

Ocrevus (Ocrelizumab) Referral Form



REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics and insurance information
- ☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
- ☐ Hep B antigen and Hep B Core total antibody required; serum immunoglobulins recommended
- ☐ Last MRI
- ☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis: ☐ Multiple Sclerosis (ICD-10 _____)		
Initial Dose: ☐ 300 mg in 250 mL NS IV at weeks 0 and 2 Maintenance Dose: ☐ 600 mg in 500 mL NS IV every 6 months Refill: ☐ PRN x 1 year OR _____ times Protocol Pre-Medication Orders: ☐ Methylprednisolone SS 125 mg IV ☐ Diphenhydramine 25 mg IV OR ☐ Diphenhydramine 25 mg PO ☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO Additional Pre-Medication Orders (optional): ☐ Other: _____		
Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician Labs: _____ Frequency: _____		
Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed ☐ May use Burnham's Vital Care flush and catheter maintenance protocol		
Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care ☐ May use Burnham's Vital Care anaphylaxis protocol		
Additional Instructions: 		
Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

ALABAMA

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MISSISSIPPI

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