



OCREVUS® (ocrelizumab) Referral Form

RETURN COMPLETED FORM VIA FAX TO:

888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	State License: _____ NPI #: _____
City, State, Zip: _____	DEA: _____ Phone: _____
Phone: _____ Alt. Phone: _____	Address: _____ Fax: _____
DOB: _____ Gender: M F Last 4 SSN: _____	City, State, Zip: _____
WT: _____ HT: _____ Allergies: _____	Contact Person: _____ Phone: _____

INSURANCE INFORMATION - INSTEAD - just send us a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance: _____	RX Card (PBM): _____
City, State, Zip: _____	BIN: _____ PCN: _____
Plan #: _____	City, State, Zip: _____
Group #: _____	Group #: _____
Phone: _____	Phone: _____

DIAGNOSIS/CLINICAL INFORMATION

<input type="checkbox"/> G35 – Multiple Sclerosis	
<input type="checkbox"/> G36 - Other acute disseminated demyelination	
<input type="checkbox"/> G37 – Other demyelinating diseases of the central nervous system	
<input type="checkbox"/> Other Code: _____	Description: _____

PREVIOUS THERAPIES

<input type="checkbox"/> Rebif	<input type="checkbox"/> Betaseron	<input type="checkbox"/> Avonex	<input type="checkbox"/> Tysabri	<input type="checkbox"/> Ocrevus
Date of last infusion: _____				
Additional Information: Has patient had the Hep B Screening? Yes/No JCV Status: Negative/Positive, Index Value: _____				

PRE-MEDICATION

STANDARD PROTOCOL	ADDITIONAL
<input type="checkbox"/> Acetaminophen 500mg <input type="checkbox"/> Diphenhydramine PO or IV 25mg <input type="checkbox"/> Solumedrol 125mg SIVP	<input type="checkbox"/> Acetaminophen 1000mg <input type="checkbox"/> Zyrtec 10mg PO

Ocrevus Infusion Orders

DRUG	DOSE	DIRECTIONS	REFILLS
OCREVUS®	<input type="checkbox"/> 300mg IV (Loading Dose)	At 0 and 2 weeks	
	<input type="checkbox"/> 600mg IV (Maintenance Dose)	Every 6 months	

SIGNATURE

X _____ DATE: _____

Prescribing Physician Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.