# Ocrelizumeb (Ocrevus®) Referral Form

**Phone** 405.548.4848 **Toll Free** 888.848.4588 **Fax** 405.418.4442

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Date of Referral: | |
| Address: | SSN: | Gender: |
| City, State: | DOB: | Age: |
| Zip: | Primary Language: | |
| Phone: | Work Phone: | |
| Caregiver Name (if other): | Relation: | Phone: |
| Emergency Contact: | Relation: | Phone: |
| Primary Insurance Subscriber: | | |
| Policy #: Group #: | Insurance Phone: | |

## PRIMARY DIAGNOSIS

**Date of diagnosis/yrs with disease:**

☐ G35 - Multiple Sclerosis

☐ Other - Please indicate ICD10-CM code & description below.

**Please Attach and Fax**
1. Insurance card(s) and demographic information
2. Recent clinical assessment note or H&P
3. Current medication list

## MEDICAL HISTORY

| | | | |
|---|---|---|---|
| **Is patient diabetic:** ☐ Yes ☐ No | | **Patient Allergies:** | ☐ NKDA |
| **Ht:** ☐ in ☐ cm | **Date Taken:** | ☐ Yes, listed: | |
| **Wt:** ☐ lbs ☐ kg | | | |

**Other Medical History:**

## PRESCRIPTION AND ORDERS

**Is this first dose?** ☐ Yes ☐ No **If no, date first dose given:**

**Access:** ☐ Peripheral ☐ Port ☐ Other:

| PREMEDICATIONS: | ORDERS: |
|---|---|
| • Solu-Medrol 100mg IV<br>• Diphenhydramine 25mg - 50mg po<br>• APAP 500mg - 1000mg po | Ocrevus® 300mg IV on Day 1, then 300mg 2 weeks later, then 600mg IV every 6 months; starting 6 months from Day 1 |

**IV CATHETER CARE:**

- Dressing changes PRN
- Antimicrobial disk PRN
- Cathflo 2mg IV to each lumen PRN occlusion
- Heparin and saline flush per OptionOne protocol
- Lab draws from urine

| POST-MEDICATIONS: KVO | LAB ORDERS: |
|---|---|
| • Sodium Chloride 0.9% 100mL IV | ☐ |

**ADDITIONAL ORDERS:**

***Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.***

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Name: | Hospital/Clinic: | |
| Address: | Office Contact: | |
| City, State, Zip: | Phone: | Fax: |
| License #: | UPIN: | NPI: |

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

***Signature:***

***Date:***