VEROS HEALTH
Excellence in Complex Care

OCREVUS® REFERRAL FORM

Please complete the following and send with clinical documentation to:
fax to 844.544.9000 or email to referrals@veroshealth.com

REFERRAL PROCESS

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician's name:
Address:	License #: NPI #:
City: State: Zip:	DEA #:
Home Phone: Other Phone:	Address:
Email:	City: State: Zip:
DOB: Social Security #:	Office Contact:
Gender: ☐ M ☐ F Height: Weight:	Phone: Fax:
Allergies: ____	

3. DIAGNOSIS: G35 Multiple Sclerosis
☐ Relapsing-remitting ☐ Primary progressive
Has the patient been previously treated for this condition?
☐ Yes ☐ No
Has the patient tried and failed other medication(s)?
☐ Yes ☐ No
List other drugs that have failed: ____
_

Is the patient currently on therapy? ☐ Yes ☐ No
Number of relapses in the past year: ____
Last MRI date: ____ Any Changes? ☐ Yes ☐ No
TB Test: ☐ Positive ☐ Negative
Hepatitis B virus screening: ☐ Yes ☐ No Date: ____
(Please attach records)
Is patient pregnant or nursing ☐ Yes ☐ No

4. INSURANCE INFORMATION: Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION Anticipated Start Date: _____

Prescription*: OCREVUS® 300mg/10ml vial* for intravenous use
☐ Initial dose: Ocrevus 300mg IV on week 0 and 2
☐ Subsequent doses: Ocrevus 600mg IV every 6 months
☐ If patient tolerates doses 1-3 at standard infusion rates, may infuse subsequent infusions at rapid infusion rates per package insert
*Each 300mg dose must be diluted in 250 mls of 0.9% Sodium Chloride for injection

☐ **Pre-medicate with the following at least 30 minutes prior to infusion:**
☐ Methylprednisolone 125mg IV push ☐ Diphenhydramine 25-50mg IV or PO ____
☐ Acetaminophen 650 - 1000mg PO ____ ☐ Other: ____

☐ PRN medications: Acetaminophen 650mg po every 4-6 hours as needed for symptom management and Diphenhydramine 25-50mg po every 4-6 hours as needed for symptom management

Other: _____

Access: ☐ Peripheral Other: ____

FLUSH ORDERS
PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml
Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS
Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
☐ Other: _____
Additional Instructions: _____

6. LABS

Prior to each infusion:
☐ CBC ☐ CD-20
☐ CMP ☐ Immunoglobulin panel

Once annually:
☐ Vitamin D 25-OH
☐ Other: _____

7. PHYSICIAN'S SIGNATURE (required): _____ Date: _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in an outreach to the prescriber.