

**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: <input type="checkbox"/> M <input type="checkbox"/> F Height: Weight:	Phone: Fax:
Allergies: _____	

<p><b>3. DIAGNOSIS:</b> G35 Multiple Sclerosis</p> <p><input type="checkbox"/> Relapsing-remitting <input type="checkbox"/> Primary progressive</p> <p>Has the patient been previously treated for this condition?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient tried and failed other medication(s)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>List other drugs that have failed: _____</p>	<p>Is the patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Number of relapses in the past year: _____</p> <p>Last MRI date: _____ Any Changes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>TB Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>Hepatitis B virus screening: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p> <p><i>(Please attach records)</i></p> <p>Is patient pregnant or nursing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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**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**

<b>Prior to each infusion:</b>	<b>Once annually:</b>
<input type="checkbox"/> CBC <input type="checkbox"/> CD-20	<input type="checkbox"/> Vitamin D 25-OH
<input type="checkbox"/> CMP <input type="checkbox"/> Immunoglobulin panel	<input type="checkbox"/> Other: _____

**7. PHYSICIAN'S SIGNATURE (required):** \_\_\_\_\_ Date: \_\_\_\_\_