

Ocrevus® (ocrelizumab) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 Code: SEE BELOW	Last Treatment Date:	Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

CBC w/ diff every _____
CMP every _____
Hepatic Function Panel every 6 months
Quantitative IgG Levels every 12 months
Vitamin D-25-OH every 12 months

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

OCREVUS ADMINISTRATION

300 mg IV at 0 and 2 weeks, then 600 mg every 6 months
600mg IV every 6 months

REQUIRED ICD-10 CODE

G35.A Relapsing-remitting multiple sclerosis
G35.B0 Primary progressive multiple sclerosis, unspecified
G35.B1 Active primary progressive multiple sclerosis
G35.B2 Non-active primary progressive multiple sclerosis
G35.C0 Secondary progressive multiple sclerosis
G35.C1 Active secondary progressive multiple sclerosis
G35.C2 Non-active secondary progressive multiple sclerosis
G35.D Multiple sclerosis, unspecified

REQUIRED DOCUMENTATION

Patient Demographics	HepB Surf Ag (within 12 months)
Insurance Card/Information	Hep B Core AB (within 12 months)
Progress Notes Supporting DX	Current Medication List and H&P
Quantitative Immunoglobulin	Complete Metabolic Panel

Provider Name (Print)

Provider Signature

Date

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	

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