

# Ocrevus® (ocrelizumab) Referral Form



**Patient Preferred Clinic** (select one):

## PATIENT INFORMATION

**Referral Status:**

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:		Weight (lbs/kg):	Height:
ICD-10 Code (required):	ICD-10 Description:	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:

## NURSING

Infusion to be administered per Vivo protocols.

## LABORATORY ORDERS

- CBC at each dose every \_\_\_\_\_
- CMP at each dose every \_\_\_\_\_
- CRP at each dose every \_\_\_\_\_

\*\*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 THERAPY ADMINISTRATION

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

## 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  |                                  |

**Type of MS:** Relapsing Remitting      Primary Progressive

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

Provider Name (Print)      Provider Signature      Date

Email Referrals To: [referrals@vivoinfusion.com](mailto: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: 800-540-1852 | New Jersey: 800-540-1852 | Pennsylvania: 215-399-9244 |                         |