

PATIENT INFORMATION			
Name:			DOB:
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon <input type="checkbox"/> Effingham <small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis		ICD 10 Code: G35	
<input type="checkbox"/> Secondary Progressive Multiple Sclerosis		ICD 10 Code: G35	
<input type="checkbox"/> Primary Progressive Multiple Sclerosis		ICD 10 Code: G35	
REQUIRED DOCUMENTATION			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Pregnancy Test (if applicable)		<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody	
Current MS treatment and end of current therapy date:			
MEDICATION ORDERS**			
Dosing Wt for Calculations		Ht:	Wt (in kg):
		BMI:	**Patient weight required for weight-based orders.
Initial Dosing	<input type="checkbox"/> Ocrevus 300mg IV at Week 0 and 2		
Maintenance Dosing	<input type="checkbox"/> Ocrevus 600mg IV Every 6 months		
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses (all doses including initial loading)			
PREMEDICATIONS			
<input type="checkbox"/> Acetaminophen 650mg PO, 30-60 minutes prior to Ocrevus infusion <input type="checkbox"/> Diphenhydramine 25mg PO, 30-60 minutes prior to Ocrevus infusion (recommended by manufacturer) <input type="checkbox"/> Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion (recommended by manufacturer) <input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS			
<input type="checkbox"/> Urine pregnancy test prior to first infusion			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:		Office Fax:	
Prescriber Signature:		Office Email:	
		Date: Time:	

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:

Fax Completed Form and all documentation to:

☐ MATTOON

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☐ EFFINGHAM

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