

Ocrevus® (ocrelizumab) Referral Form



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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

[x] Infusion to be administered per BioHealth protocols.

OCREVUS THERAPY ADMINISTRATION

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

LABORATORY ORDERS

[] CBC at each dose every
[] CMP at each dose every
[] CRP at each dose every
OTHER

REQUIRED DOCUMENTATION

PREMEDICATIONS

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

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

Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
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