Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35.A
☐ Primary Progressive Multiple Sclerosis, unspecified	ICD 10 Code: G35.B0
☐ Active Primary Progressive Multiple Sclerosis	ICD 10 Code: G35.B1
☐ Non-Active Primary Progressive Multiple Sclerosis	ICD 10 Code: G35.B2
☐ Secondary Progressive Multiple Sclerosis, unspecified	ICD 10 Code: G35.C0
☐ Active Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35.C1
☐ Multiple Sclerosis, unspecified	ICD 10 Code: G35.D

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ MRI of Brain	☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody (must be within 1 year)
*Patient may be required to submit a pregnancy test prior to treatment	

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	☐ J2350 Ocrevus 300mg IV at Week 0 and 2
Maintenance Dosing	☐ J2350 Ocrevus 600mg IV Every 6 months

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses (all doses including initial loading)**

**Infusions will be titrated to maximum recommended rate as suggested in prescribing information.

PREMEDICATIONS

☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg IV Push or PO
☐ Methylprednisolone 100mg Slow IV Push
☐ Other: _____

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :

Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		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
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

INFUSION ORDERS - OCREVUS (OCRELIZUMAB)

Clinics Scan to: Physician Orders