

**Patient Information**

Patient Name: _____		DOB: _____	
Patient Home Phone: _____	Patient Cell Phone: _____	Patient Email: _____	
Emergency/Alternate Contact Name: _____		Emergency/Alternate Contact Phone: _____	
NKDA	Allergies: _____	Weight lbs/kg: _____	Height: _____
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
			Last infusion date (if applicable): _____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
		Does the patient need interpreter services:	
		Yes	No

**Provider Information**

Referral Coordinator Name: _____		Referral Coordinator Email: _____	
Ordering Provider: _____		Provider NPI: _____	
Referring Practice Name: _____		Phone: _____	Fax: _____
Practice Address: _____		City: _____	State: _____ Zip: _____

**ICD-10 CODE**

G35 Multiple Sclerosis      Other: \_\_\_\_\_

**Medication Order**

<b>Ocrevus</b> (ocrelizumab)	<b>Dose and Frequency:</b>	Induction: 300mg IV on day 1 and day 15
		Maintenance: 600mg IV every 6 months (starting 6 months from the first infusion date)

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (Hep B and Serum Immunoglobulins)

Insurance Card (front and back)

Current Medications

History/Progress Notes

**Pre-Medication Order**

<b>acetaminophen</b> (Tylenol)      1000mg PO	<b>diphenhydramine</b> (Benadryl)      50mg IV
<b>methylprednisolone</b> (Solu-Medrol)      100mg IV	Other: _____

**Customized Pre-Medication Order**

Drug: \_\_\_\_\_

Dose: \_\_\_\_\_      Route: \_\_\_\_\_      Frequency: \_\_\_\_\_

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**
**Provider Name**
**Provider Signature**
**Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

**Patient Information**

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

**Lab Test (Please circle or write in ICD-10)**

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CALCIUM	M81.0, M81.8	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	PSA	R97.20, C61, N40.1, Z12.5, N40.0
CREATININE	M81.0, M81.8, G35	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
G6PD	M1A.9XX0, M1A.9XX1	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
GROWTH HORMONE	E22, C7A.1, E34	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	

**Frequency**

Prior to each dose      Yearly      Other: Please Specify Below

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

 \_\_\_\_\_  
**Provider Name**

 \_\_\_\_\_  
**Provider Signature**

 \_\_\_\_\_  
**Date**

 \_\_\_\_\_  
**Provider Phone**