Ocrevus (ocrelizumab)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal **Infusion Office Preference:** _____

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
☐ NKDA Allergies:	Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy - Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

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
☐ Non-active secondary progressive multiple sclerosis	ICD-10 Code: G35.C2
☐ Multiple sclerosis, unspecified	ICD-10 Code: G35.D

REQUIRED DOCUMENTATION/Testing	
☐ Recent LFT ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ Labs and Tests supporting primary diagnosis ☐ Hepatitis B Test Results: Hep B surface antigen & Hep B Core TOTAL Antibody
List Tried & Failed Therapies 1)	2)

PREMEDICATION ORDERS

☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg
☐ diphenhydramine (Benadryl) PO / IV ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)
☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐ 100 mg ☐ _____ mg
☐ other:

Note: manufacturer recommended premedication regimen is Solu-Medrol and Benadryl

MEDICATION ORDERS	
Initial Dosing	☐ Ocrevus 300mg IV at weeks 0 and week 2
Maintenance dosing	☐ Ocrevus 600mg IV every 6 months

Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ **(if not indicated order will expire one year from date signed)*

SPECIAL INSTRUCTIONS

☐ Urine pregnancy test prior to dose

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record. Modified 9/16/25