Ocrevus® (Ocrelizumab) Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

10750 W. Howard Ave
Greenfield, WI 53228
Phone: (414) 460-3195 Fax:
(414) 763-0063
www.gtinfusions.com

Patient Information	
Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart ☐ Medication/Order Change ☐ D/C Infusions

Diagnosis and ICD 10 Code	
☐ Relapsing forms of Multiple Sclerosis	ICD 10 Code: **G35**
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: **G35**
☐ Other Diagnosis:	ICD 10 Code:

Required Documentation

☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests including Anti-JCV antibodies
☐ Tried and Failed therapies	☐ Current Medication and Allergy List

Medication Orders

☐ Initial/Reloading Dose: Ocrevus® - 300mg IV - Day 0 and 300 mg - Day 14

☐ Maintenance Dose: Ocrevus® - 600 mg IV every six months

Notes (Additional Info)

Premedication, adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.

Prescriber Information

Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order is valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.