

Ocrevus® (Ocrelizumab) Referral Form



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Patient Information		
Patient Name:		Patient DOB:
Referral Status		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Restart	<input type="checkbox"/> Medication/Order Change
		<input type="checkbox"/> D/C Infusions
Diagnosis and ICD 10 Code		
<input type="checkbox"/> Relapsing forms of Multiple Sclerosis	ICD 10 Code: G35	
<input type="checkbox"/> Primary Progressive Multiple Sclerosis	ICD 10 Code: G35	
<input type="checkbox"/> Other Diagnosis:	ICD 10 Code:	
Required Documentation		
<input type="checkbox"/> Patient demographics	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis	
<input type="checkbox"/> Copy of patient insurance card(s) – front & back	<input type="checkbox"/> Labs and tests including Anti-JCV antibodies	
<input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> Current Medication and Allergy List	
Medication Orders		
<input type="checkbox"/> Initial/Reloading Dose: Ocrevus® - 300mg IV - Day 0 and 300 mg - Day 14		
<input type="checkbox"/> 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: <small>(Order is valid for one year)</small>
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.		

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