1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-7987
Fx: 972-787-1492

OCREVUS INFUSION REFERRAL FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Patient Weight: ____________kg ; _____________lbs

DIAGNOSIS AND ICD 10 CODE			
☐ MS Relapsing - Remitting	ICD 10 Code: ___________	☐ Clinically Isolated	ICD 10 Code: ___________
☐ Primary Progressive	ICD 10 Code: ___________	☐ Other: ____________	ICD 10 Code: ___________
☐ Secondary Progressive	ICD 10 Code: ___________	____________________	

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics and Insurance Card	☐ Labs and MRI to supporting primary diagnosis
☐ Hepatitis B: HBsAg & HBcAb antibody results	☐ First Dose -or- ☐ **Last given dose:**______________
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	PA Guidance: Patient is not receiving Ocrevus in combination interferon beta preparations, dimethyl fumarate, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, teriflunomide, rituximab, belimumab, ofatumumab, alemtuzumab, or mitoxantrone

ORDERS			
Dosing	☐ Ocrevus **300mg** in 250ml 0.9% Normal Saline IV at 0 and 2 weeks ☐ Ocrevus **600mg** in 500ml 0.9% Normal SalineIV every 6 months for 1 year ☐ Solumedrol IV 125mg mg via slow IVP as premed ☐ Benadryl IV 25-50mg via slow IVP as premed		
Infusion orders	☐ Nurse to start, pause, or discontinue peripheral or central venus access device as needed ☐ Flush IV line with 10-20ml saline before and after each medication dose or as needed ☐ Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed ☐ Dispense DME pump with all necessary supplies for home infusion		
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS)			
Refills:	☐ X 6 months	☐ X 1 year	☐ _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		NPI #:
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023