

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis (MS)	ICD 10 Code: G35	
<input type="checkbox"/> Secondary Progressive Multiple Sclerosis (MS)	ICD 10 Code: G35	
<input type="checkbox"/> Primary Progressive Multiple Sclerosis (MS)	ICD 10 Code: G35	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> Hepatitis B test results: ABsAg & Total HepB core Antibody (must be within 1 year)	
Current MS treatment and end of current therapy date:		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____		
Initial Dosing	<input type="checkbox"/> J2350 Ocrevus 300mg IV at week 0 and 2	
Maintenance Dosing	<input type="checkbox"/> J2350 Ocrevus 600 mg IV Every 6 months	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
**Infusions will be titrated to maximum recommended rate as suggested in prescribing information.		
PREMEDICATIONS/ LAB ORDERS		
<input type="checkbox"/> Acetaminophen _____ mg PO	<input type="checkbox"/> CBC	<input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____
<input type="checkbox"/> Benadryl _____ mg PO or IV	<input type="checkbox"/> CMP	<input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____
<input type="checkbox"/> Methylprednisolone _____ slow IV push	<input type="checkbox"/> Other: _____ Date: _____	
<input type="checkbox"/> Other: _____		
ADDITIONAL ORDERS/INFORMATION		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – OCREVUS (OCRELIZUMAB)