RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Ocrevus Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Fax #:	

Ocrevus Medication Orders

Dosage

- ______ Initial: 300mg IV on day 1, followed by 300mg 2 weeks later
- ______ Maintenance: 600mg IV once every 6 months (beginning 6 months after the first 300mg dose)
- ______ Other ____

Patient Weight: ________ Lbs or _______ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Multiple sclerosis • Other _______________________
- ICD 10 code ____

Standard Pre-Medications for Ocrevus	Refills
• Tylenol 100 mg PO • Benadryl 50mg IV slow push • Solumedrol 100mg IV Push • Other ________________	• Zero _______ • Treatments for 1 year __________ • Other ___________

Required Documentation

○ **Insurance Cards (Front and Back)** ○ **Demographics** ○ **Recent Progress Notes**

○ **Lab Results – CMP, CBC, Hep B screening prior to initiation**

Special Instructions/Notes

____________________________________ ______________________

Prescribing Provider Signature **Date of Signature**