Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

Diagnosis	ICD 10 Code
☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
☐ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)
☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody (must be within 1 year)

Current MS treatment and end of current therapy date:

MEDICATION ORDERS**

Dosing Wt for Calculations	Ht:	Wt (in kg):	BMI:	**Patient weight required for weight-based orders.
Initial Dosing	☐ J2350 Ocrevus 300mg IV at Week 0 and 2			
Maintenance Dosing	☐ J2350 Ocrevus 600mg IV Every 6 months			
Duration	☐ **X 6 months**	☐ **X 1 year**	☐ ________ **doses (all doses including initial loading)**	

**Infusions will be titrated to maximum recommended rate as suggested in prescribing information.

PREMEDICATIONS

☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg IV Push or PO
☐ Methylprednisolone 100mg Slow IV Push
☐ Other: ______________________________

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr.
Suite 204
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Fax 217-348-2579

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