arise infusion
THERAPY SERVICES

Advanced Treatment for Osteoporosis and Inflammatory Diseases

WHEATON • ROCKVILLE • OLNEY • CHEVY CHASE • FREDERICK • WASHINGTON, DC

OCREVUS (*Ocrelizumab*) INFUSION REFERRAL CHECKLIST

Patient Name: _____ Date: _____

DOB: _____

Referring Physician: _____ Referring Office Contact: _____

Phone: _____ Fax: _____ Address: _____

Diagnosis: _____ ICD Code: _____

Please include the type of multiple sclerosis the patient has been diagnosed with:

☐ Relapsing-remitting MS ☐ Secondary-progressive MS ☐ Primary-progressive MS ☐ Progressive-relapsing MS

Ambulate: ☐ Independent ☐ With Assistance ☐ Wheelchair ☐ Stretcher

Special Instructions: _____

_____

Please send the following documents and records:

- Patient Demographics – Including preferred contact number for patient
- Copy of the patient's insurance card(s) – Front AND Back
- Ocrevus order signed and dated by referring physician
- Last three office notes (One must include discussion of Ocrevus)
- Most recent Labs to include HBV surface antigen test (CBC and CMP if available)
- Most recent MRI report
- Medication History
- Statement of Medical Necessity (SMN) form supplied by Genentech/AccessSolutions

PLEASE FAX TO 301-424-3590 USING THIS FORM AS THE COVERSHEET

www.ariseinfusion.com
CENTRAL CALL CENTER: 240-514-5000
FAX: 301-424-3590