

OCREVUS (Ocrelizumab) ORDER FORM

REFERRAL TYPE				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Restart	<input type="checkbox"/> Frequency Change	<input type="checkbox"/> Dosage Change
PREFERRED LOCATION				
<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815		
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 71 Thomas Johnson Drive Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006		
	<input type="checkbox"/> 8270 Willow Oaks Corporate Drive Suite 150 Fairfax, VA 22031			
PATIENT INFORMATION				
Name:		DOB:	Email:	
Address:		Weight:	KG	LBS
				Phone:
REFERRING PHYSICIAN INFORMATION				
Name:			NPI:	
Office Contact Name:		Phone:	Fax:	
Address:				
OCREVUS ORDER				
OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.				
Dosing/Frequency:				
<input type="checkbox"/> Initial Dose: 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months <input type="checkbox"/> Maintenance Dose: 600mg IV over 3.5hrs every 6 months <input type="checkbox"/> Maintenance Dose: 600mg IV over 2hrs every 6 months				
Diagnosis:				
<input type="checkbox"/> G35—Multiple Sclerosis Please identify the type of MS the patient has been diagnosed with: <input type="checkbox"/> Relapsing-remitting MS <input type="checkbox"/> Secondary-progressive MS <input type="checkbox"/> Primary-progressive MS <input type="checkbox"/> Progressive-relapsing MS				
<input type="checkbox"/> Other Diagnosis:			ICD-10 Code (Required):	
Ambulate: <input type="checkbox"/> Independent <input type="checkbox"/> With Assistance <input type="checkbox"/> Wheelchair NOTICE: ARISE cannot facilitate treatment for patients on a stretcher.				
Special Instructions:				
Physicians Signature:			Date: <i>(Order is Valid for One Year)</i>	
REQUIRED DOCUMENTATION				
Please fax the following documents and records:				
<ul style="list-style-type: none"> ● Patient Demographics ● Two most recent office notes (Supporting the DX and treatment ordered) ● Most recent labs that include values for: <ul style="list-style-type: none"> ● CMP, CBC, HBV Surface Antigen ● Most recent MRI report 		<ul style="list-style-type: none"> ● Copy of the patient's insurance card(s) – front and back ● Medication History ● For continuation of treatment, include the last infusion note ● Statement of Medical Necessity (SMN) form supplied by Genentech/AccessSolutions 		
<i>We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</i>				