OCREVUS (ocrelizumab) Referral Order Form

Fax 888.615.1445

Precisionhc

clinically advanced infusion care

WWW.PRECISIONHC.COM
Phone: 615.367.1444 FAX: 888.615.1445

☐ New Referral ☐ Restart ☐ Medication/ Order Change (New Order Required) ☐ Benefits Verification Only ☐ Refill / Renewal

Precision Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

OCREVUS MEDICATION ORDERS

Patient Weight: _____ **kg**

☐ Initial/Reload Dosing: 300mg IV Day 1, 300mg IV Day 15

☐ Maintenance: 600mg IV every 6 months
Observe for 1 hour post – infusion

INDICATION/DIAGNOSIS (required)

***ICD-10 Code/Description** _____

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Premedications: (based on package insert:)

☐ Methylprednisolone 100 mg IV once (recommended)

☐ Diphenhydramine 50 mg IV once (recommended)

☐ Acetaminophen 650 mg PO once

☐ Other: _____

Refills x 1 year (unless otherwise specified)
May use Precision Allergy Reaction Protocol

LAB ORDERS FOR PRECISION NURSING TO DRAW (please specify)

Orders: _____

Frequency: _____

NOTES (ADDITIONAL INFO OR ORDERS)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet ☐ Allergies

ATTACH REQUIRED LAB RESULTS (For New Referrals Only)

☐ HepB panel (w/in 12 months) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE AND TIME: _____

FOR OFFICE USE ONLY