

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	Lbs Kg
Patient Status:		Next due date (if applicable):	

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Multiple Sclerosis () Other ()

***Labs: Hep B and Baseline IgG levels required prior to initial infusion**

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)

Administer 920mg SQ in the abdomen over approx. 10 min Q6 months

*Monitor one hour after the initial injection and for 15 minutes after subsequent injections

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A

Acetaminophen	500mg	650mg	1000mg	
Fexofenadine (Allegra)	180mg PO	(or other non-sedating antihistamine)		
Diphenhydramine (Benadryl)	25mg	50mg	PO	IV (requires driver)
Methylprednisolone (Solu-Medrol)	40mg	80mg	125mg	IV
Prednisone	_____ mg PO			
Other	_____			

POST-MEDICATIONS N/A

Acetaminophen	500mg	650mg	1000mg
Prednisone	_____ mg PO		
Other	_____		

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE