Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

OCREVUS® (OCRELIZUMAB) ORDER FORM

(- Required Fields)*

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

Locations:

-------**Oklahoma**-------
___ Tulsa

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐ M ☐ F
ADDRESS:		PHONE:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

OCREVUS ORDER*:

ICD-10*: _____

*(SELECT **ONE** OF THE FOLLOWING)*

_____ **Initial/Loading Dose and then Maintenance Dosing:**
300mg IV at 0 and 2 weeks, then 600mg IV every 6 months

OR

_____ **Maintenance Dosing**: 600mg IV every 6 months

Okay to Infusion After: _____

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Relapsing Multiple Sclerosis
_____ Primary Progressive MS
_____ Other_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and procedure)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ HepB Surf Ag (w/in 12 months)
_____ HepB Core Ab (w/in 12 months)

Current MS Drug:_____

Pt to Stop Therapy _____ weeks before starting Ocrevus

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

REVISION DATE- 5/2019