WAYNE HEALTH

ocrelizumab (Ocrevus®) Order Form **FAX to 1 (888) 797-4008**

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? ☐ Yes ☐ No		

Order date:	Weight: kg	Height: m
Drug allergies: ☐ NKDA. ☐ YES. Please specify.		
ICD-10 diagnosis:		
PREVIOUS THERAPIES		
☐ Rebif	☐ Betaseron	☐ Ocrevus; last date of infusion:
☐ Avonex	☐ Tysarbi	

LABORATORY DATA		
CBC:	BMP:	Serology:
Quantitative serum immunoglobulin:		Other:

Hepatitis Screen			
HBsAg: ☐ Pos ☐ Neg	HBsAb: ☐ Pos. ☐ Neg	HBcAb: ☐ Pos. ☐ Neg	Date:

ocrelizumab (Ocrevus®)		
Dose	**Directions**	**Refills**
☐ 300 mg IV	☐ once at wk 0 and at wk 2 (loading)	
☐ 600 mg IV	☐ once q 6 months (maintenance)	
☐ Other	☐ Other	

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:

WAYNE HEALTH

Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.