SPRINGSIDE INFUSION

Ocrevus

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis

☐ Relapsing-remitting multiple sclerosis, ICD 10: g35.a
☐ Active primary progressive multiple sclerosis, ICD 10: g35.b
☐ Non-active primary progressive multiple sclerosis, ICD 10: g35.b2
☐ Active progressive secondary multiple sclerosis, ICD 10: g35.c1
☐ Clinically isolated syndrome (cis), ICD 10: g36.9
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications

☐ N/A
☐ Provider prescribed: _____

Medication order

Dose

☐ Initial treatment: 300 mg at week 0 and 2, then 600 mg every 6 months
☐ Initial treatment: 300 mg at week 0 and 2, then 600 mg every 24 weeks
☐ Maintenance treatment: 600 mg every 6 months
☐ Maintenance treatment: 600 mg every 24 weeks
☐ Other _____

Frequency

N/A
☐ Other _____

Medication route

☐ IV
☐ Other _____

Lab order (Include frequency)

Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

Prerequisites

Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative Hep B test results | Baseline liver function tests (LFTs) (alt, ast, bilirubin, alkaline phosphatase) within 6 months

Please send to ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

Referring provider information

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____