

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 | Frequency |
| | <input type="checkbox"/> 920 mg/23 mL ocrelizumab and 23,000 units hyaluronidase | <input type="checkbox"/> Every 6 months |
| | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

- Medication route** Subcutaneous injection in abdomen
 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 | 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 _____