OCREVUS Referral Order Form

FAX (855) 891-2191

Effective: 04/2017

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

_____

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

OCREVUS MEDICATION ORDERS

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

INDICATION/DIAGNOSIS

☐ Multiple Sclerosis

***ICD-10** _____ **required**

_____ _____

Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along w/ any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Hep B antigen and Hep B total Core antibodies (w/in past 12 months)

☐ JCV Antibody (if available)

☐ CMP (w/in past 3 months, if available)

☐ CBC with differential (w/in past 3 months, if available)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY