

Effective: 07/2017

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191 Email: mppreferral@mppinfusion.com

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

INDICATION/DIAGNOSIS

Multiple Sclerosis

Current MS Drug: _____

Pt to Stop Therapy wks before starting Ocrevus

***ICD-10 _____ required**

NOTES (ADDITIONAL INFO)

Referring Physician's Signature

Date *valid for one year

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)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY