Ocrevus Order Form

Pre-filled order form for Ocrevus (ocrelizumab) — Disease-modifying therapy for MS

REFERRING PROVIDER

PROVIDER NAME | NPI | DEA (IF CONTROLLED) | SPECIALTY

PRACTICE / CLINIC NAME | OFFICE PHONE | OFFICE FAX

OFFICE CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX | PATIENT PHONE | BEST TIME TO CONTACT

ADDRESS | CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE | MEMBER ID | GROUP #

SECONDARY INSURANCE (IF ANY) | MEMBER ID | GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS | ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE) | ICD-10 CODE

Common indications for this medication: *Relapsing forms of multiple sclerosis (RRMS, SPMS, CIS), Primary progressive multiple sclerosis (PPMS)*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

OCREVUS REFERENCE

Generic name:	ocrelizumab
Specialty:	Neurology
Typical infusion time:	2.5–3.5 hours per infusion
Typical schedule:	Initial split-dose, then every 6 months

MEDICATION ORDER

MEDICATION (DEFAULT: OCREVUS)

GENERIC / ALT (OCRELIZUMAB)

STRENGTH / FORMULATION

DOSE

FREQUENCY (TYPICAL: INITIAL SPLIT-DOSE, THEN EVERY 6 MONTHS)

DURATION (TYPICAL: 2.5&NDASH;3.5 HOURS PER INFUSION)

ROUTE

PRE-MEDICATIONS (IF ANY)

SPECIAL INSTRUCTIONS

ANTICIPATED START DATE

 # OF DOSES AUTHORIZED

SUBSTITUTION ALLOWED (Y/N)

BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Arbor to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE

PRINTED NAME

DATE

Form code: ARB-ORDER-OCREVUS · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com