



Phone: (865) 862 - 4557

[www.heartlandinfusion.com](http://www.heartlandinfusion.com)

Fax: (865) 862 - 4556  
Alt. Fax: (865) 867 - 7081

### Ocrevus Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

<b>Referral Status:</b>	<input type="checkbox"/> New referral	<input type="checkbox"/> Dose or frequency change	<input type="checkbox"/> Order Renewal
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**PATIENT INFORMATION**

Name:			
Home Phone:		Cell Phone:	
Email:		Last four Social Security number	
DOB:		Height:	Weight:
Allergies:			
ICD-10 Diagnosis Code:		Years with Disease:	
TB Test (Circle One):		Result:	Date:
Skin	Quantiferon	Chest Xray	

**LABORATORY ORDERS**

<input type="checkbox"/> CBC w/ Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Quantiferon TB (annually)		Due:	_____
<input type="checkbox"/> Other: _____			

**Therapy Orders**

<input type="checkbox"/> Induction: Administer Ocrevus (ocrelizumab) 300mg IV on Day 1 and Day 15
<input type="checkbox"/> Maintenance: Administer Ocrevus (ocrelizumab) 600mg IV every six months
<b>OR</b> other (specify): _____
<input type="checkbox"/> Nursing per Heartland Nursing Procedures (incl reaction management)

**Pre-Medications**

<input type="checkbox"/> Tylenol (acetaminophen) _____ mg PO	<input type="checkbox"/> No routine pre-medications required
<input type="checkbox"/> Solu-Medrol (methylprednisolone) _____ mg IV	<input type="checkbox"/> Zyrtec (cetirizine) 10 mg PO
<input type="checkbox"/> Benadryl (diphenhydramine) _____ mg <input type="checkbox"/> PO	<input type="checkbox"/> Claritin (loratadine) 10 mg PO
<input type="checkbox"/> Other: _____	<input type="checkbox"/> IV

**PHYSICIAN INFORMATION**

Physician's Name:		
License #:	NPI#:	DEA#:
Address:		
City:	State:	Zip:
Office Contact:	Email:	
Office Phone:	Office Fax:	

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient is being referred to:  Knoxville  Morristown  Kingsport