MICHIGAN INSTITUTE FOR NEUROLOGICAL DISORDERS (MIND)

INFUSION TREATMENT REFERRAL FORM

Infusion Center Locations: CHECK ONE:

☐ **MIND Farmington Hills**
28595 Orchard Lake Rd
Farmington Hills, MI 48334

☐ **MIND Roseville**
25100 Kelly Road
Roseville, MI 48066

Main telephone Number: 248.553.0010 Fax Number: 248.553.6222
www.mindonline.com

Patient Name: _____ Date of birth: _____

Patient Address: _____ Phone Number: _____

Allergies: _____

OCREVUS (OCRELIZUMAB)

Please mark diagnosis:

☐ Multiple Sclerosis (ICD-10 Code: _____) ☐ Secondary Progressive
☐ Relapsing Remitting ☐ Primary progressive **Please Include:**
☐ Copy of Insurance card (front and back)
☐ Copy of Driver's License (front and back)
☐ Clinical progress notes/labs/tests supporting primary diagnosis
☐ Current History and Physical with updated medication list included
☐ Most recent MRI
☐ Prior to initial dosing labs: CBC with diff, CMP, Hepatitis panel, QuantiFERON Gold, Quantitative immunoglobulin panel, VZV IgG
☐ Subsequent dosing required labs: CBC with diff, CMP, Quantitative immunoglobulin panel, T and B Lymphocyte panel (lymphocyte subset panel)

Date of Last MS treatment: Type: _____ Dose: _____ Date: _____

Infusion Orders: (Annual order renewal needed)

Ocrevus: ☐ Loading Dose: 300mg IV (subsequent dose 2 weeks apart), then 600mg IV every 24 weeks
☐ Subsequent Dose: 600mg IV every 24 weeks using shorter infusion interval **Pre-medications:** ☐ Tylenol 1000mg PO ☐ Solumedrol 125mg IVP ☐ Benadryl 50mg IVP ☐ Pepcid 20mg IVP ☐ Other: _____

By signing this form and utilizing our services, you are authorizing MIND and its employees to serve as your prior authorization and pharmacy designated agent in dealing with medical and prescribing companies.

Physician Name: _____
Physician Signature: _____ Date: _____
Phone number: _____ Fax Number: _____

Additional Services available at MIND

Mark needed services and a MIND representative will reach out for further information ☐

MRI ☐ EEG ☐ EMG ☐ OCT