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MICHIGAN INSTITUTE *for* NEUROLOGICAL DISORDERS

Ocrevus Infusion
Outside Referral Form

Infusion Center Locations *(Please Select One)*	
☐ **MIND Farmington Hills** **28595 Orchard Lake Rd, Suite 200** **Farmington Hills, MI 48334**	☐ **MIND Roseville** **25100 Kelly Rd** **Roseville, MI 48066**

	Please include the following documents:
☐	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 & 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)

Demographics	
Patient Name:	
Date of Birth:	
Patient Address:	
Phone Number:	
Allergies:	
Diagnosis Code:	Multiple Sclerosis/ (ICD-10 Code: G35)

Infusion Orders									
Ordered Infusion: ***(Please select one)***	☐ Ocrevus 300mg IV Infusion in 250mL NS (subsequent dose 2 weeks apart) start at 30mL/hr and increase by 30mL/hr Q30 mins until reach max rate of 180mL/hr ☐ Ocrevus 600mg IV Infusion in 500mL NS every 24 weeks								
Infusion Rates for 600mg dose: ***(Please select one)***	☐ Option 1 (approximately 2-hour infusion)				☐ Option 2 (approximately 3.5-hour infusion)				
	0-15 min 100mL/hr	**16-30min** 200mL/hr	**31-60min** 250mL/hr	**61-end of infusion** 300mL/hr	**0-30min** 40mL/hr	**31-60min** 80mL/hr	**61-90min** 120mL/hr	**91-120min** 160mL/hr	**121-end of infusion** 200mL/hr

Pre-Medications ***(Please select all that apply)***	☐ Tylenol 1g PO ☐ Tylenol 650mg PO ☐ Benadryl 25mg PO ☐ Benadryl 50mg PO ☐ Benadryl 50mg IVP ☐ Solu-Medrol 40mg IVP ☐ Solu-Medrol 125mg IVP
Additional Orders:	

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:** ___________________________

Please fax completed form to 248.553.6222