



Select referral location:

Akron	Columbus (East Broad)	Findlay	Toledo
Athens	Columbus (Hilliard)	Liberty	Crestview Hills (NKY)
Cincinnati (Blue Ash)	Columbus (Worthington)	Mansfield	
Cincinnati (West)	Dayton (Beavercreek)	Perrysburg	
Cleveland	Dayton (Englewood)	Springfield	

Ocrevus Order Form

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State Zip
Office Contact:	Email:
Office phone:	Office fax:

4. DIAGNOSIS INFORMATION (and year of diagnosis)

Multiple Sclerosis () ICD 10 () Other: _____ ***Hep B, TB, and IG levels required prior to initial infusion**

5. PRESCRIPTION INFORMATION (requires new order every 12-months)

OCREVUS	Initial	Maintenance	PRE-MEDICATIONS	N/A
Initial Dose: Administer 300mg intravenous infusion, followed two weeks later by a second 300mg intravenous infusion			Acetaminophen	500mg 650mg 1000mg
Maintenance Dose: 600mg intravenous infusion every 6 months			Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Vital signs per HI Protocol			Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Anaphylaxis & Hydration Management per HI Protocol			Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
			Prednisone _____ mg PO	
			Other _____	
			POST-MEDICATIONS	N/A
			Acetaminophen	500mg 650mg 1000mg
			Prednisone _____ mg PO	
			Other _____	

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date):	_____	
Other (specify):	_____	

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE