Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Ocrevus Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 Attn: Idyllic Infusion Coordinator

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI Tax ID#	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	▫ Voorhees ▫ Moorestown ▫ Wall/Manasquan ▫ Sewell ▫ Hamilton ▫ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

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The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Name (last, first) _____DOB: _____
Diagnosis:

☐ G35 Multiple Sclerosis ☐ Other: _____

Is this a Continuation of Care or a new start to the medication?

☐ Continuation of Care (Provide record of last administration)
☐ New Rx

The following information is required for authorization for multiple sclerosis:

- Which type of MS does the patient have? ☐ CIS ☐ RRMS ☐ PPMS ☐ SPM
  - If the patient has PPMS, please provide all component scores of the Functional Systems Scale.
  - Please provide documentation of all relapses within the past 2 years.
  - Provide MRI reports documenting status of current lesions and changes from prior scans.
- Does the patient have a history or presence at screening of elevated IgG index or at least 1 IgG oligoclonal band in CS fluid? ☐ YES ☐ NO
- Has the pt. been neurologically stable for the past 30 days? ☐ YES ☐ NO
- Does the patient have any other neurological disorders which may mimic multiple sclerosis? ☐ YES ☐ NO
- If the patient is being treated with another disease-modifying MS therapy, will it be discontinued prior to starting Ocrevus? ☐ YES ☐ NO
- Will the patient be ALSO receiving immunosuppressive therapy? ☐ YES ☐ NO
- Has the pt. had a live/attenuated vaccine within the past 6 weeks? ☐ YES ☐ NO
- Please provide negative results for HBsAg and anti-HBV.
- Does the patient have either progressive multifocal leukoencephalopathy or active primary or secondary immunodeficiency? ☐ YES ☐ NO

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.

    - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- Include recent chart notes, scans, tests, labs to support the start of OCREVUS.
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
    - *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
    - Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !! Please notify our office if OCREVUS should be discontinued.**

▫ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature:

_____