

(ocrelizumab)

Date: _____

OCREVUS infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

☐ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS Please provide ICD-10 code

☐ _____ Multiple Sclerosis ☐ _____ (other)

PRE-MEDICATION

☐ Tylenol 1000mg PO ☐ _____ (other)

☐ Cetirizine 10mg PO ☐ _____ (other)

OCREVUS ORDERS

DOSAGE

☐ 300mg IV initial dose, followed 2 weeks later by a second 300mg IV dose

☐ subsequent to first 2 doses, 600mg IV dose every 6 months

☐ Other _____

PREMEDICATION PER PRESCRIBING INFORMATION

PATIENT WEIGHT

☒ Solu-medrol 100mg IV 30 minutes prior to each treatment _____ lbs.

☐ Diphenhydramine 25mg PO 30-60 minutes prior to each treatment _____ kg

Total dosage ☐ /refills _____

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____