Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

(ocrelizumab)

Date: _____

OCREVUS infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

NPI _____ Tax ID _____ ◯ Allergies

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

◉ Solu-medrol 100mg IV 30 minutes prior to each treatment

◯ Diphenhydramine 25mg PO 30-60 minutes prior to each treatment

Total dosage ☐ /refills_____

PATIENT WEIGHT

_____lbs.

_____kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____