

OCREVUS

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ G35.A (Relapsing-Remitting Multiple Sclerosis) ☐ G35.B1 (Active Primary Progressive MS)
☐ G35.C1 (Active Secondary Progressive MS) ☐ Other: _____

Allergies: _____ Weight: _____ ☐ Kg ☐ Lbs Height: _____ ☐ cm ☐ in

Active Infection Present: ☐ Yes ☐ No HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No Ig Panel Completed: ☐ Yes ☐ No

TREATMENT INFORMATION

OCREVUS (ocrelizumab)

Route: Intravenous infusion

Dose: ☐ 300mg ☐ 600mg

Frequency:

☐ Induction: Day 1: 300mg IV

Day 15: 300mg IV

☐ Maintenance: 600mg IV every 6 months

☐ Observe patient for 1 hour post infusion

Quantity: _____ Refills: _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV

☐ Other: _____

Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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