

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M / F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs / kg  
Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Patient Preferred Location: \_\_\_\_\_

<ICD 10 CODE REQUIRED>

**DIAGNOSIS & CLINICAL INFORMATION**

ICD 10 Code

G35 Multiple Sclerosis

Other: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy. LAB RESULTS: Include Negative Hepatitis B within 3 years to initiate therapy.**

**PRESCRIPTION**

Pre-Medications

Required:

Acetaminophen: 500 mg PO, may repeat q 4-6 hours, PRN infusion reaction

Diphenhydramine: 25 mg PO, may repeat q 6 hours, PRN infusion reaction

Diphenhydramine: 25 mg IVP, may repeat q 6 hours, PRN infusion reaction

Methylprednisolone: 125 mg SIVP

Other: \_\_\_\_\_

**Ocrevus (ocrelizumab)**

Loading Dose:

**IV:** Infuse 300 mg in 250 mL of 0.9% Sodium Chloride over at least 2 hours and 30 minutes via pump using a 0.2-micron filter at weeks 0 and 2

Maintenance Dose: (FROM WEEK 0)

**IV:** Infuse 600 mg in 500 mL of 0.9% Sodium Chloride over at least 2 hours and 30 minutes via pump using a 0.2-micron filter every 6 months for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

**Post Treatment Observations:** The patient is observed for 60 minutes following each infusion.

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ *Signature:* \_\_\_\_\_

Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Supervising Physician: \_\_\_\_\_ (If Applicable)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_