Ocrevus Order Form
(ocrelizumab)

FAX TO: 972.499.9210

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 Relapsing Remitting Multiple Sclerosis

☐ G35 Primary Progressive 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

Select Route:

☐ 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 2 hours or longer 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: _____