

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 yearIs the patient on any other disease modifying therapy? **Yes** **No**

If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 60 minutes following the first administration.**Adverse Events:** In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions**Comments:****PRESCRIBER INFORMATION**

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____