



INFUSION ORDERS-OCREVUS (OCRELIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>
 Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis ICD 10 Code: G35 <input type="checkbox"/> Secondary Progressive Multiple Sclerosis ICD 10 Code: G35 <input type="checkbox"/> Primary Progressive Multiple Sclerosis ICD 10 Code: G35

REQUIRED DOCUMENTATION
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Pregnancy Test (if applicable) <input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
Current MS treatment and end of current therapy date:

MEDICATION ORDERS**
Initial dosing <input type="checkbox"/> Ocrevus 300mg IV given at week 0 and 2
Maintenance Dosing <input type="checkbox"/> Ocrevus 600mg IV every 6 months
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses (all doses including initial loading)

** Infusions will be titrated to maximum recommended rate as suggested in prescribing information.

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO, 30-60 minutes prior to Ocrevus infusion <input type="checkbox"/> Diphenhydramine 25mg PO, 30-60 minutes prior to Ocrevus infusion (recommended by manufacturer) <input type="checkbox"/> Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion (recommended by manufacturer) <input type="checkbox"/> Other:

OTHER TESTING (Optional)
<input type="checkbox"/> Urine pregnancy test prior to first infusion

PRESCRIBER INFORMATION
Prescriber Name:
Office Phone: Office Fax: Office Email:
Prescriber Signature: Date: