

Ocrevus (ocrelizumab)

**METRO INFUSION CENTER**REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION	
Date:	Patient Name: DOB:
☐ NKDA Allergies:	Weight (lbs / kg): Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:	Next Due Date:
PROVIDER INFORMATION	
Office Contact Name:	Office Email:
Prescribing Providers Name:	Provider NPI:
Office Address:	City: State: Zip:
Office Phone Number:	Office Fax Number:
DIAGNOSIS AND ICD 10 CODE	
☐ Relapsing-Remitting multiple sclerosis	ICD-10 Code: G35.A
☐ Primary Progressive multiple sclerosis, unspecified	ICD-10 Code: G35.B0
☐ Active secondary progressive multiple sclerosis	ICD-10 Code: G35.C1
☐ Multiple sclerosis, unspecified	ICD-10 Code: G35.D
REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ Hepatitis B Test Results: Hep B surface antigen & Hep B Core TOTAL Antibody ☐ Liver Function Test results
List Tried & Failed Therapies 1)	2)
PREMEDICATION ORDERS	
☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg ☐ diphenhydramine (Benadryl) PO / IV ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)) ☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐ 100 mg ☐ _____ mg ☐ other:	<i>Note: manufacturer recommended premedication regimen is Solu-Medrol and Benadryl</i>
MEDICATION ORDERS	
Initial Dosing	☐ Ocrevus 300mg IV at weeks 0 and week 2
Maintenance dosing	☐ Ocrevus 600mg IV every 6 months
Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ <i>*(if not indicated order will expire one year from date signed)</i>	
SPECIAL INSTRUCTIONS	
☐ Urine pregnancy test prior to dose	

Provider Name (Print)

Physician Signature:

Date:

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Modified 10/1/25