Patient Name:____________________________________

DOB:_____________________ Wt(kg):________________

Allergies:__________________ Phone:________________

Ocrevus (Ocrelizumab) Infusion Orders

Required Information:

- Signed order from prescribing provider
- Patient demographics including insurance information
- Supporting clinical documentation: Visit notes, lab & imaging results
- Last TB & Hep B results

Primary Diagnosis:

Multiple Sclerosis(ICD-10:_____________)

Other:__________________(ICD-10:________________)

OCREVUS ORDERS

Initial Dose: Ocrevus 300mg at 0 and 2 weeks

Subsequent Dose: Ocrevus 600mg every 6 months

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____mg

PO Cetirizine _____mg

IV Solu-medrol _____mg

PO Loratadine _____mg

PO IV Diphenhydramine _____mg

PO IV Other:______________ _____mg

LABS

CBC	ESR	Uric Acid
CMP	TB Quantiferon Gold	Other:______
CRP	Hep B Core/Surface AG	Other:______

Frequency: Every Infusion
Every Other Infusion
One time only
Other:______________

CPL Acct #:__________

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

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Physician Name:	Phone:	Fax:
Physician Signature:	**NPI:**	**Date:**