Ocrevus (ocrelizumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____ _____
Allergies **Weight** **Patient Phone**

Diagnosis (must include ICD-10 code)
☐ **Multiple Sclerosis** _____

Prescription Orders: Ocrevus (ocrelizumab)

0.2 micron filter must be used during infusion

☐ **Initial dosing:** Infuse 300mg IV in 250ml NS over a minimum of 2.5 hours on day 0 and 14. Monitor patient for 1 hour after the completion of each infusion.

☐ **Subsequent and renewal dosing:** Infuse 600mg in 500ml NS over a minimum of 3.5 hours every 6 months. Monitor patient for 1 hour after the completion of each infusion.

Start date: _____ **Last infusion:** _____

Premeds: **Solu-medrol** ☐ _____ mg IVP ☐ **Claritin** 10mg PO ☐ **Zyrtec** 10mg PO
☐ **Benadryl** _____ mg IVP or PO ☐ **Acetaminophen** _____mg PO
Other Premeds: _____

(Give 30 minutes prior to infusion)

Refills: ☐ 12 months or ☐ for _____ infusions

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com