Local Infusion

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OCREVUS (OCRELIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
❑ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
❑ Active Primary progressive multiple sclerosis (PPMS), ICD 10: G35.B1
❑ Non-active Primary progressive multiple sclerosis (PPMS), ICD 10: G35.B2
❑ Clinically isolated syndrome (CIS), ICD 10: G36.9
❑ Relapsing-remitting MS, in pediatric patients 10 years of age and older who weigh 25 kg or more, ICD 10: G35.A

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Methylprednisolone (Solu-Medrol) 125mg IVP

☑ Benadryl 25mg PO

☑ Famotidine 20mg IV

☑ Acetaminophen (Tylenol) 500mg PO

❑ Cetirizine (Zyrtec) 10mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Ocrevus	❑ Initial Treatment: 300 mg at Week 0 and 2, then 600 mg ❑ Maintenance Treatment: 600 mg	IV	❑ Every 24 weeks ❑ Every 6 months

LABS / SPECIAL INSTRUCTIONS