



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

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:

Contact us with questions at: info@rosenursing.net
or call **954.432.8290**

Fax completed form and all documentation to **844.246.3364**

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