

# OCREVUS (OCRELIZUMAB) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

MS, ICD 10: G35

Relapsing Forms of MS (RMS)     Primary Progressive MS (PPMS)

Other: \_\_\_\_\_

## 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     Start form completed

## PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO

Famotidine 20 mg IV

Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO

Cetirizine (Zyrtec) 10 mg PO

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Ocrevus	<input type="checkbox"/> Initial Treatment: 300 mg at Week 0 and 2, then 600 mg <input type="checkbox"/> Maintenance Treatment: 600 mg	<input type="checkbox"/> IV	<input type="checkbox"/> Every 24 weeks <input type="checkbox"/> Every 6 months

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS:  NH: 603.217.5371     ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_