Local Infusion

MYLOCALINFUSION.COM

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

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

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371
❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

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