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 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

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