

(ocrelizumab)

OCREVUS infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

_____ Multiple Sclerosis

_____ (other)

PRE-MEDICATION

Tylenol 1000mg PO

Cetirizine 10mg PO

Length of Need _____

(other)

OCREVUS ORDERS

DOSAGE/FREQUENCY

300mg IV initial dose, followed by 2 weeks later by a second 300mg IV dose
subsequent to first 2 doses, 600mg IV does every 6 months

PATIENT WEIGHT

_____ lbs.

_____ kg

PREMEDICATION PER PRESCRIBING INFORMATION

Solu-medrol 100mg IV 30 minutes prior to each treatment

Diphenhydramine 25mg PO 3-60 minutes prior to each treatment

Refills: _____

Notes

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887