

OCREVUS (OCRELIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Comments: _____
 New Start Therapy | Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

- Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
- Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
- Active primary progressive multiple sclerosis (PPMS), ICD 10: G35.B1
- Acute disseminated demyelination, unspecified, ICD 10: G36.9

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

PRE-MEDICATION

These will be given to patient unless otherwise specified.

Methylprednisolone (Solu-Medrol) 125mg IVP Benadryl 25mg PO Acetaminophen (Tylenol) 500mg PO
 Famotidine 20mg IV **or** Cetirizine (Zyrtec) 10mg 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: 600 mg	IV	<input type="checkbox"/> Every 24 weeks (Every 6 months)

OTHER NOTES

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