

OCREVUS (OCRELIZUMAB)



PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ lbs kg

Allergies: _____ NKDA

Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

Multiple Sclerosis (MS) G35 Relapsing Forms of MS (RMS) G35.11 Primary Progressive MS (PPMS) G35.2

Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

- | | | | |
|---|---------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Acetaminophen (Tylenol) PO | <input type="checkbox"/> 500 mg | <input type="checkbox"/> 650 mg | <input type="checkbox"/> 1000 mg |
| <input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> PO <input type="checkbox"/> IV | <input type="checkbox"/> 25 mg | <input type="checkbox"/> 50 mg | |
| <input type="checkbox"/> Methylprednisolone (Solu-Medrol) IV | <input type="checkbox"/> 40 mg | <input type="checkbox"/> 125 mg | |
| <input type="checkbox"/> Cetirizine (Zyrtec) 10 mg PO | | | |
| <input type="checkbox"/> Other: _____ | | | |

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input type="checkbox"/> OCREVUS (Ocrelizumab) IV in 0.9% sodium chloride, intravenous infusion	<input type="checkbox"/> 300 mg	<input type="checkbox"/> Induction Dose: at 0 and 2 weeks,
<input type="checkbox"/> OCREVUS (Ocrelizumab), SQ	<input type="checkbox"/> 600 mg <input type="checkbox"/> 920 mg	<input type="checkbox"/> Maintenance Dose: every 6 months <input type="checkbox"/> Maintenance Dose: every 6 months

Refills Zero 12 months _____ Order valid for 1 year unless otherwise stated. _____

- Flush with 0.9% sodium chloride at infusion completion.
 Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

- | | | |
|--------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> CBC | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Other | <input type="checkbox"/> at each dose | <input type="checkbox"/> every _____ |

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

- Patient Demographics Insurance card Progress Notes supporting DX Hepatitis B Results
 Quantitative serum immunoglobulin screening

Provider Signature _____

Date _____