Provider Order Form

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

☐ Acetaminophen (Tylenol) PO	☐ 500 mg	☐ 650 mg	☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV	☐ 25 mg	☐ 50 mg	
☐ Methylprednisolone (Solu-Medrol) IV	☐ 40 mg	☐ 125 mg	
☐ Cetrizine (Zyrtec) 10 mg PO			

☐ Other: ______________________

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ OCREVUS (Ocrelizumab) IV in 0.9% sodium chloride, intravenous infusion	☐ 300 mg	☐ Induction Dose: at 0 and 2 weeks, then 600mg every 6 months
	☐ 600 mg	☐ 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

☐ CBC	☐ at each dose	☐ every _____________
☐ CMP	☐ at each dose	☐ every _____________
☐ CRP	☐ at each dose	☐ every _____________
☐ Other _______________	☐ at each dose	☐ 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