COMMUNITY HEALTH INTERVENTIONS SPECIALTY CLINIC

Community Health Interventions Specialty Clinic

INFUSION ORDERS-OCREVUS (OCRELIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE	
☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
☐ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Pregnancy Test (if applicable)	☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
Current MS treatment and end of current therapy date:	

MEDICATION ORDERS**				
Initial dosing	☐ Ocrevus 300mg IV given at week 0 and 2			
Maintenance Dosing	☐ Ocrevus 600mg IV every 6 months			
Refills:	☐ X	6 months	☐ X 1 year	☐ _____doses (all doses including initial loading)

** Infusions will be titrated to maximum recommended rate as suggested in prescribing information.

PREMEDICATIONS
☐ Acetaminophen 650mg PO, 30-60 minutes prior to Ocrevus infusion
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to Ocrevus infusion (recommended by manufacturer)
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion (recommended by manufacturer)
☐ Other:

OTHER TESTING (Optional)
☐ Urine pregnancy test prior to first infusion

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: jeff@eastoninfusion.com or call 728-777-5546

Fax completed form and all documentation to **(561) 709-8626**

All information contained in this form is strictly confidential and will become part of the patient's medical record.