Ocrevus (ocrelizumab)

Provider Order Form rev. 5/202022

AleraCare
A Healthcare Solutions Company
www.aleracare.com
ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ G35 Multiple Sclerosis

☐ Other: _____

PRE-MEDICATION ORDERS

(give 30 minutes before each infusion)
Standard Protocol:

☐ acetaminophen (Tylenol) 1000mg PO

☐ diphenhydramine (Benadryl) 50mg IV

☐ methylprednisolone (Solu-Medrol) 100mg IV

☐ Other: _____

Customized Pre-Medication Order

Drug: _____

Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Ocrevus (ocrelizumab)

Dose and Frequency :

☐ Induction: 300mg IV on day 1 and day 15

☐ Maintenance: 600mg IV every 6 months
(starting 6 months from the first infusion date)

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**