aleracare
advanced infusion centers™

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Ocrevus (ocrelizumab)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

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

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ G35 Multiple Sclerosis ◯ Other: _____

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)

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (Hep B and Serum Immunolobulins)

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

Pre-Medication Order

Standard Protocol *(give 30 minutes before each infusion):*

◯ **acetaminophen** (Tylenol) ◯ 1000mg PO ◯ **diphenhydramine** (Benadryl) ◯ 50mg IV

◯ **methylprednisolone** (Solu-Medrol) ◯ 100mg IV ◯ Other: _____

Customized Pre-Medication Order

Drug: _____

Dose:_____ Route:_____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____

_____ _____ _____

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯