(ocrelizumab)

OCREVUS infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ _____

☐ _____
(other)

OCREVUS ORDERS

DOSAGE/FREQUENCY

○ 300mg IV initial dose, followed by 2 weeks later by a second 300mg IV dose

subsequent to first 2 doses, 600mg IV does every 6 months

PATIENT WEIGHT

_____ lbs.

_____ kg

PREMEDICATION PER PRESCRIBING INFORMATION

◉ Solu-medrol 100mg IV 30 minutes prior to each treatment

○ Diphenhydramine 25mg PO 3-60 minutes prior to each treatment

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____

Please return by fax to: (806) 503-2200 or email to: referrals@icareama.com.