Ocrevus (Ocrelizumab) Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
☐ Hep B antigen and Hep B Core total antibody required; serum immunoglobulins recommended
☐ Last MRI
☐ Documentation of any tried and failed therapies

Patient Name:	**DOB:**	**Weight:**
Allergies:	**Patient Phone:**	

Diagnosis:
☐ Multiple Sclerosis (ICD-10 _____)

Initial Dose: ☐ 300 mg in 250 mL NS IV at weeks 0 and 2

Maintenance Dose: ☐ 600 mg in 500 mL NS IV every 6 months

Refill: ☐ PRN x 1 year OR _____ times

Protocol Pre-Medication Orders:

☐ Methylprednisolone SS 125 mg IV

☐ Diphenhydramine 25 mg IV OR ☐ Diphenhydramine 25 mg PO

☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO

Additional Pre-Medication Orders (optional):

☐ Other: _____

Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician

Labs: _____ Frequency: _____

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed

☐ May use Burnham's Vital Care flush and catheter maintenance protocol

Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care

☐ May use Burnham's Vital Care anaphylaxis protocol

Additional Instructions:

Practitioner Name:	**Practitioner Signature:**	**Date:**

Practitioner Address: