☐ New Prescription/Referral
☐ Prescription Refill

# OCREVUS (ocrelizumab)

**Rx:**

**Patient Name:**

**DOB:**

**MEDICATION/Strength:** **OCREVUS (ocrelizumab)**

**ROUTE:** ☐ Peripheral IV ☐ PICC ☐ Midline ☐ Port ☐ SubQ ☐ IM

☐ Initial dose of 300mg IV for 2.5 hrs;
☐ 2nd dose 300mg IV for 2.5 hrs to be given after 2 wks;
☐ Subsequent doses of 600mg IV for 2-4 hrs Q6 months

Others:

**Dx:** ○ Multiple Sclerosis (G35) ○ Others ( **Dx + ICD Code 10**):

**Pre-Medication (30-60 mins prior to treatment):**

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others:

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

**ANA Kit Protocol:**
☐ OK to use

**NPI#:**

**DEA#:**

**Physician Signature**

**Date: (Valid for 1 year)**

## PHYSICIAN INFORMATION

**Physician Name:**

**CLINIC:**

**Contact Information:**

**Phone:** **Fax:** **Email:**

**Other:**

**Office Mailing Address:**

**Check that the following are included:**

☐ **Patient demographics & Insurance attached**
☐ **Clinical progress notes**
☐ **History and Physical**
☐ **Lab Results**
☐ **Other Test Results**
☐ **Diagnosis (supporting)**
☐ **Medication List**