Intravene – OCREVUS Order Form (rev 4/2017)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434) 455-5531 or call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____
Height _____ Weight _____lbs
Drug Allergies_____
□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone(_____)_____
Physician Fax(____)_____
NPI#_____DEA#_____
State License#_____

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and this form to 434-455-5531

DIAGNOSIS: (ICD-10 required)

- ☐ G35 Multiple Sclerosis
- ☐ _____

PRE TREATMENT SCREENING:
Hepatitis B Screening: Date/ Results:_____
Hepatitis C Screening: Date/Results:_____

STANDARD ORDERS:
Infuse Ocrevus 300mg in Normal Saline 250ml at 0 and 2 weeks. Then Ocrevus 600mg in Normal Saline 500ml every 6 months. Infuse by manufacturer titration protocol. Upon completion of Ocrevus infusion, infuse Normal Saline 50ml to clear line.

Premedications:
Methylprednisolone 100mg IV 30 minutes prior to infusion.
Diphenhydramine 25mg-50mg PO or IV 30 min. prior to infusion.
Acetaminophen 650mg PO 30 minutes prior to infusion.

LABS: _____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD _____Date _____