

**Intravene – OCREVUS Order Form (rev 5/2021)**

**Please fax this form along with a copy of insurance cards and clinical documentation to: (434) 455-5531 or call (434) 947-3900 ext. 3001**

**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# \_\_\_\_\_

**\*\*Please fax copies of insurance cards\*\*  
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: \_\_\_\_\_

**Quantitative Serum Immunoglobulin Screening:** Date: \_\_\_\_\_ Attach 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 20- 100ml 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 \_\_\_\_\_**