Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067

ThrIVewell INFUSION WEST
Office: 310-481-9944 Fax : 310-766-7001

MMI

(ocrelizumab)

OCREVUS infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City: State:	Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ _____ *(other)*

OCREVUS ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:

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

☐ Subsequent to first 2 doses, 60mg IV dose every 6 months

☐ Other _____

PREMEDICATION PRE PRESCRIBING INFORMATION:

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

☐ Diphenhydramine 25mg PO 30-60 minutes prior to each treatment

Total dosage ☐/refills_____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____