

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



(ocrelizumab)

Date: _____

OCREVUS infusion orders

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> 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, 600mg 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 _____