

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



(ocrelizumab)

Date: _____

OCREVUS infusion orders

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, 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 _____