Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

Office: 212-803-3339 Fax : 646-768-8600

(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, 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 ____________