

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



(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	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> 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 <i>Please provide ICD-10 code</i>
<input type="checkbox"/> _____ Multiple Sclerosis
<input type="checkbox"/> _____ <i>(other)</i>
PRE-MEDICATION
<input type="checkbox"/> Tylenol 1000mg PO
<input type="checkbox"/> Cetirizine 10mg PO
<input type="checkbox"/> _____ <i>(other)</i>
<input type="checkbox"/> _____ <i>(other)</i>

OCREVUS ORDERS
PATIENT WEIGHT
_____ lbs.
_____ kg
DOSAGE:
<input type="checkbox"/> 300mg IV initial dose, followed 2 weeks later by a second 300mg IV dose
<input type="checkbox"/> Subsequent to first 2 doses, 600mg IV dose every 6 months
<input type="checkbox"/> Other _____
PREMEDICATION PRE PRESCRIBING INFORMATION:
<input type="checkbox"/> Solu-medrol 100mg IV 30 minutes prior to each treatment
<input type="checkbox"/> Diphenhydramine 25mg PO 30-60 minutes prior to each treatment
Total dosage <input type="checkbox"/> /refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ _____ Phone _____ Fax _____