INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ocrevus *ocrelizumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
☐ Active primary progressive multiple sclerosis (PPMS), ICD 10: G35.B1
☐ Non-active primary progressive multiple sclerosis (PPMS), ICD 10: G35.B2
☐ Clinically isolated syndrome (CIS), ICD 10: G36.9
☐ Relapsing-remitting MS in pediatric patients 10 years and older who weigh 25 kg or more, ICD 10: G35.A

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
☐ Labs and tests supporting diagnosis
☐ Baseline liver function tests (LFTs) (ALT, AST, bilirubin, alkaline phosphatase) within 6 months
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

☑ Acetaminophen (Tylenol) 500 mg PO
☑ Famotidine 20 mg IV
☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
☑ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Ocrevus	☐ Initial treatment: 300 mg at week 0 and 2, then 600 mg ☐ Maintenance treatment: 600 mg	IV	☐ Every 24 weeks ☐ Every 6 months

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____