HONORHEALTH®

OCRELIZUMAB
(Ocrevus)
Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status ☐ New Order ☐ Renewal ☐ Dose or Frequency Change

Diagnosis	☐ Multiple sclerosis, relapsing or primary progressive ☐ Other: ______________________	**Diagnosis Code:** ____________

Required Information (Please include labs attached)

Allergies:

Diagnostic Hepatitis B Panel	Date:	Weight:
Negative Quantiferon TB or T-Spot or chest x-ray	Date:	
Coccidioides Screen/Panel	Date:	Height:
CBC, CMP (include lab result documents)	Date:	

Labs ☐ CBC, CMP every ________________ ☐ Other:

Pre-Medications

☐ Acetaminophen
☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine PO or IV (circle one)
☐ 25 mg ☐ 50 mg

☐ Methylprednisolone IV
☐ 60 mg ☐ 100 mg ☐ other:

☐ Other:

Induction:
☐ Ocrevus 300mg IV on day 1 and day 14

Maintenance:
☐ Ocrevus 600mg IV every 6 months

☐ Other:

Infusion Reaction Medications Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.

Required Documentation

- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: