Ocrevus
(ocrelizumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Multiple sclerosis (G35)

Type: ☐ RRMS ☐ SPMS ☐ PPMS ☐ PRMS ☐ CIS

☐ Other: _____

PRESCRIPTION

Ocrevus (ocrelizumab)

☐ Initial Dose: Ocrevus 300mg IV on Day 1 & Day 15, then 600mg IV every 6 months after initial dose

☐ Maintenance Dose: Ocrevus 600mg IV every 6 months

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- MRI Results
- Negative Hep B
- Immunoglobulin Panel

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. *(See aiscaregroup.com for detailed policy)*

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV 30 minutes prior to start of infusion

☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.