NORTH TEXAS INFUSION CENTERS

Ocrevus (ocrelizumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____ _____
Allergies **Weight** **Patient Phone**

Diagnosis (must include ICD-10 code)
☐**Multiple Sclerosis** _____

Prescription Orders: Ocrevus (ocrelizumab)

0.2-micron filter must be used during infusion

☐**Initial dosing:** Infuse 300mg IV in 250ml NS over a minimum of 2.5 hours on day 0 and 14.
Monitor patient for 1 hour after the completion of each infusion.

☐**Subsequent and renewal dosing:**
☐Infuse 600mg in 500ml NS over a minimum of 3.5 hours every 6 months.
☐Infuse 600mg in 500ml NS over a minimum of 2 hours every 6 months.
Monitor patient for 1 hour after the completion of each infusion.

Start date: _____ **Last infusion:** _____

Premeds: **Solu-Medrol** ☐_____ mg IVP ☐**Claritin** 10mg PO ☐**Zyrtec** 10mg PO
☐**Benadryl** _____ mg IVP or PO **Acetaminophen** _____mg PO
Other Premeds: _____

(Give 30 minutes prior to infusion)

Refills: ☐12 months or ☐for _____ infusions

_____
Provider Name **Phone** **Fax**

_____
Provider's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com

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