



Physician-led • Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:  
FAX: 410-220-2553

**OCREVUS ORDER**

New Start  Maintenance: Last Dose Given \_\_\_\_\_

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies  NKDA  Allergies:

\_\_\_\_\_ Height: \_\_\_\_\_

\_\_\_\_\_ Weight: \_\_\_\_\_

**Indication:**

G35 Relapsing Remitting Multiple Sclerosis

G35 Primary Progressive Multiple Sclerosis

Other \_\_\_\_\_

**DOSAGE ORDERS:**

Induction: 300mg IV on Day 1 and Day 15

Maintenance: 600mg IV every 6 months

Other \_\_\_\_\_

**PREMEDICATION ORDERS:** *antihistamine and 100mg methylprednisolone are recommended in the PI*

Acetaminophen po:  1000mg  500mg 30 min prior to infusion.

Diphenhydramine:  25mg PO  50mg PO  25mg IVP 30 min prior to infusion.

Solu-Medrol:  62.5mg IVP  100mg IVP  Other \_\_\_\_\_ 30 min prior to infusion.

Other \_\_\_\_\_

Prescriber Name: Title:

NPI:	DEA:
Prescriber Signature: Date of Order:	

**Referrals will not be processed until we receive ALL the following:**

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC  CMP  TB  Hep B Other: \_\_\_\_\_