

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- G35.A Relapsing-Remitting MS (RRMS) G35.B2 Non-Active Primary Progressive MS (PPMS)
 G35.B0 Primary Progressive MS (PPMS), unspecified G35.C1 Active Secondary Progressive MS (SPMS)
 G35.B1 Active Primary Progressive MS (PPMS) G35.D Multiple Sclerosis, unspecified

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- Insurance Information List of Medications Tried & Failed Therapies Most Recent History & Physical
 Negative Hepatitis B Quantitative Serum IG screening

MEDICATION ORDER

LOADING: Ocrevus® (ocrelizumab) 300mg IV in 250ml NS over 2.5 hours at week 0 and 2

MAINTENANCE: Ocrevus® (ocrelizumab) 600mg IV in 500ml NS over 2 hours or as tolerated every 6 months

* Maintenance dosing scheduled 6 MONTHS from initial Week 0 dosing

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE:

PRE-MEDICATIONS

REQUIRED

- Acetaminophen: 500 mg PO IV
 Methylprednisolone: 125 mg PO IV
 Diphenhydramine: 25 mg PO IV

OTHER: _____ PO IV

Patient to be observed for 60 minutes following each administration. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN