

OCREVUS® (ocrelizumab)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____


Required Documentation

- Patient Demographics and Insurance Card Medication List Recent lab results
 Clinical/Progress Notes Supporting Dx Hep B Status Results Quantitative serum immunoglobulins


Primary Diagnosis

-  ICD-10 Code (required): _____
 Relapsing-Remitting Multiple Sclerosis Primary Progressive Multiple Sclerosis
 Secondary Progressive Multiple Sclerosis Other: _____

Pre-Medication

- Per violet health protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 125mg IV 30 minutes prior to start of infusion 
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetrizine (Zyrtec) 10 mg PO
 Other: _____

Therapy Administration

- Ocrevus 300mg IV on Day 1 & Day 15, then 600mg IV every 6 months after initial dose
 Ocrevus 600mg IV every 6 months
 Other: _____
- Refills:**
 x 1 year Other: _____
 Order valid for one year unless otherwise stated
- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____