☐ **New Prescription/Referral**
☐ **Prescription Refill**

OCREVUS (ocrelizumab)

Rx:

Patient Name:

Patient Weight: kg

DOB:

MEDICATION/Strength: **OCREVUS (ocrelizumab)**

☐ Initial dose of 300mg IV for 2.5 hrs;
☐ 2nd dose 300mg IV for 2.5 hrs to be given after 2 wks;
☐ Subsequent doses of 600mg IV for 2-4 hrs Q6 months

Others:

ROUTE:
☐ Peripheral IV
☐ PICC
☐ Midline
☐ Port
☐ SubQ
☐ IM

Dx: ☐ Multiple Sclerosis (G35) ☐ Others (**Dx + ICD Code 10**):

Pre-Medication (30-60 mins prior to treatment):

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others:

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:
☐ OK to use

NPI#:

DEA#:

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone: **Fax:** **Email:**

Other:

Office Mailing Address:

Check that the following are included:

☐ **Patient demographics & Insurance attached**
☐ **Clinical progress notes**
☐ **History and Physical**
☐ **Lab Results**
☐ **Other Test Results**
☐ **Diagnosis (supporting)**
☐ **Medication List**
☐ **Quantitative Immunoglobulin**
☐ **HepB Surf Ag (within 12 months)**
☐ **Hep B Core AB (within 12 months)**