eMediateINFUSION center

☐ New Prescription/Referral
☐ Prescription Refill

OCREVUS (ocrelizumab)

Rx:

Patient Name:

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)

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Fax:

Other:

Email:

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