Ocrelizumab (Ocrevus)

Fax to 505-420-4848 or Email to refer@optimuminfusion.com

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ☐ G35.A: RRMS ☐ G35.B0: PPMS, Unspecified ☐ G35.B1: PPMS, Active ☐ G35.B2: PPMS, Non-Active ☐ Other
☐ G35.C0: SPMS, Unspecified ☐ G35.C1: SPMS, Active ☐ G35.C2: SPMS, Non-Active ☐ G35.D: MS, Unspecified

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per Optimum Infusion Nursing Procedures, including reaction management and post-procedure observation.

☐ Hepatitis B status & date (list results here & attach clinicals):
____

Based on the manufacturer PI, most payors require a quantitative serum immunoglobulin screening prior to Ocrevus induction.

☐ I have attached results from a recent quantitative serum immunoglobulin test (list results here & attach clinicals):
____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ famotidine (Pepcid) 20mg PO
☐ methylprednisolone (Solu-Medrol) 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: ______________________________________
Dose: ________ Route: ________ Frequency: ________________

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ____________ _______
☐ CMP ☐ at each dose ☐ every ____________ _______
☐ CRP ☐ at each dose ☐ every __________________
☐ Other: ____

REQUIRED LABS (NAÏVE PATIENTS ONLY)

☐ ALT: ____
☐ AST: ____
☐ Alkaline Phosphatase: ______________________________
☐ Bilirubin: ____

THERAPY ADMINISTRATION

☑ **Ocrelizumab** (Ocrevus) intravenous infusion
☐ Induction:
- Dose: 300mg in 250ml 0.9% sodium chloride
- Frequency: on Day 1 and Day 15
- Duration: minimum of 2.5 hours (per manufacturers guidelines)
- After induction, continue with maintenance dosing below

☐ Maintenance:
- Dose: 600mg in 500ml 0.9% sodium chloride
- Frequency: every 6 months from infusion 1 of initial dose
- Duration: minimum of 2 hours (per manufacturers guidelines)

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑ Patient required to stay for 60-min observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ __________________
(if not indicated order will expire one year from date signed)

*Hepatitis B virus and quantitative serum immunoglobulin screening are required before the first dose. *Pre-medicate with methylprednisolone (or an equivalent corticosteroid) and an antihistamine (e.g., diphenhydramine) prior to each infusion. *Monitor patients closely during and for at least one hour after infusion.

Provider Name (Print) **Provider Signature** **Date**

SUBMIT ORDER FORM TO OPTIMUM INFUSION:
☐ **FAX:** 505-420-4848
☐ **EMAIL:** refer@optimuminfusion.com

rev. 2/6/26