OCREVUS
(ocrelizumab)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- MRI Results
- Negative Hep B
- Immunoglobulins Panel
- Liver Function Tests

PRIMARY DIAGNOSIS

☐ G35.A Relapsing-remitting multiple sclerosis
☐ G35.B0 Primary progressive multiple sclerosis, unspecified
☐ G35.B1 Active primary progressive multiple sclerosis
☐ G35.B2 Non-active primary progressive multiple sclerosis
☐ G35.C0 Secondary progressive multiple sclerosis, unspecified
☐ G35.C1 Active secondary progressive multiple sclerosis
☐ G35.C2 Non-active secondary progressive multiple sclerosis
☐ G35.D Multiple sclerosis, unspecified
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV 30 minutes prior to start of infusion
☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

☐ Ocrevus 300mg IV on Day 1 & Day 15, then 600mg IV every 6 months after initial dose
☐ Ocrevus 600mg IV every 6 months
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals