Clearwell
Infusion Centers

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OCREVUS (ocrelizumab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

☐ Hepatitis B virus screening (HBsAg and anti-HBc) prior to therapy initiation required
Date performed:_____ ☐ Negative ☐ Positive

☐ Quantitative serum immunoglobulin test during treatment and after discontinuiation of treatment, until B-cell repletion, and especially in the setting of recurrent serious infections

☐ Pregnancy test (if applicable)

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

☐ Acetaminophen 1000mg PO ☐ Other:
☐ Cetirizine 10mg PO

PRIMARY MEDICATION ORDER

Dosage

☐ 300mg IV initial dose, followed by 2 weeks later by a second 300mg IV dose subsequent to first 2 doses, 600mg IV does every 6 months

Premedication Per Prescribing Information

☐ Solu-medrol 100mg IV 30 minutes prior to each treatment
☐ Diphenhydramine 25mg PO 30-60 minutes prior to each treatment

Patient Weight:

_____ lbs
_____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____