



Please fax completed form, insurance card, and clinical documentation to:  
**FAX: 843-793-6181**

**OCREVUS ORDER**

New Start  Maintenance: Last Dose Given \_\_\_\_\_

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies  NKDA  Allergies: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Indication:**

G35 Relapsing Remitting Multiple Sclerosis

G35 Primary Progressive Multiple Sclerosis

Other \_\_\_\_\_

**DOSAGE ORDERS:**

Induction: 300mg IV on Day 1 and Day 15

Maintenance: 600mg IV every 6 months

Other \_\_\_\_\_

**PREMEDICATION ORDERS:**

Acetaminophen:  1000mg PO  500mg PO 30 min prior to infusion.

Diphenhydramine:  25mg PO  50mg PO  25mg IVP 30 min prior to infusion. -REQUIRED

Methylprednisolone:  62.5mg IVP  100mg IVP  Other \_\_\_\_\_ 30 min prior to infusion. -REQUIRED

Other \_\_\_\_\_

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

**Referrals will not be processed until we receive ALL the following:**

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC  CMP  TB  Hep B
- Bilirubin
- Other: \_\_\_\_\_

**CAUTION: Monitor patient for 1 hour post infusion.**