Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Ocrevus (ocrelizumab)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

* * If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required * *

DIAGNOSIS AND ICD-10 CODE	
☐ Relapsing-Remitting Multiple Sclerosis	G35
☐ Secondary Progressive Multiple Sclerosis	G35
☐ Primary Progressive Multiple Sclerosis	G35
☐ Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ HBV Panel results	
☐ If applicable, when was the patient's last Covid-19 vaccine or booster? _____	
☐ Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1)	3)
2)	4)

MEDICATION ORDERS	
Initial Dosing	☐ Ocrevus 300mg infuse IV over 2.5 hours at weeks 0 and 2, THEN Ocrevus 600mg infuse IV over 3.5 hours every 6 months
Maintenance Dosing	☐ Ocrevus 600mg infuse IV over 3.5 hours every 6 months
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____	

REQUIRED PREMEDICATIONS and OPTIONAL ADDITIONAL PREMEDS and LAB ORDERS
☐ OPTIONAL: Acetaminophen 650mg PO prior to infusion
☒ REQUIRED: Diphenhydramine 25mg IV or PO (per patient preference) prior to infusion
☒ REQUIRED: Methylprednisolone 100mg slow IVP prior to infusion
☐ Other PreMeds or Lab Orders with frequency:_____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.