## Richmond

7110 Forest Ave, Suite 203 Richmond, VA 23226



## Prince George

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

## **Physician Order - Ocrevus (ocrelizumab)**

Name:   DOB:   Allergies:   Phone Number:   Patient Height:   In	PATIENT INFORMATION			
REFERRAL STATUS	Name: DOB:			
REFERRAL STATUS   New Referral   Dose/Frequency Change   Order Renewal	Allergies:			
REFERRAL STATUS    New Referral   Dose/Frequency Change   Order Renewal				
New Referral   Dose/Frequency Change   Order Renewal				
New Referral   Dose/Frequency Change   Order Renewal	REFERRAL STATUS			
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: Methylprednisolone 100mg slow IVP prior to infusion REQUIRED: Methylprednisolone 100mg slow IVP prior to infusion REQUIRED: Methylprednisolone 100mg slow IVP prior to infusion on the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.				
**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: Methylprednisolone 100mg slow IVP prior to infusion REQUIRED: Methylprednisolone 100mg slow IVP prior to infusion REQUIRED: Methylprednisolone 100mg slow IVP prior to infusion on the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.	Location Preference (ontional)			
** 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 Patient Demographics AND Insurance Information 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)  MEDICATION ORDERS Initial Dosing Ocrevus 300mg infuse IV over 3.5 hours every 6 months Maintenance Dosing Ocrevus 600mg infuse IV over 3.5 hours every 6 months  Maintenance Dosing Ocrevus 600mg infuse IV over 3.5 hours every 6 months  Maintenance Dosing Ocrevus 600mg infuse IV over 3.5 hours every 6 months  MEDICATION ORDERS Initial Dosing Ocrevus 600mg infuse IV over 3.5 hours every 6 months  Maintenance Dosing Ocrevus 600mg infuse IV over 3.5 hours every 6 months  Maintenance Dosing Ocrevus 600mg infuse IV over 3.5 hours every 6 months  MEQUIRED: Diphenhydramine 25mg IV or PO (per patient preference) 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.	<u> </u>			
Secondary Progressive Multiple Sclerosis   G35     Primary Progressive Multiple Sclerosis   G35     Other:	DIAGNOSIS AND ICD-10 CODE			
Primary Progressive Multiple Sclerosis   G35   ICD10				
Other:   ICD10	☐ Secondary Progressive Multiple Sclerosis G35			
REQUIRED DOCUMENTATION (must include)    This signed order form by the provider	☐ Primary Progressive Multiple Sclerosis G35			
☐ 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       3)         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:         ☐ A Faculty of the provided of the	☐ Other: ICD10			
☐ 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       3)         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:         ☐ A Faculty of the provided of the				
Patient Demographics AND Insurance Information				
HBV Panel results   If applicable, when was the patient's last Covid-19 vaccine or booster?   Last dose:   Last dose:	☐ This signed order form by the provider ☐ Clinical/Progress Notes			
If applicable, when was the patient's last Covid-19 vaccine or booster?     Patient currently receiving same therapy at	☐ Patient Demographics AND Insurance Information ☐ Labs and Tests Supporting Primary Dx			
Patient currently receiving same therapy at	☐ HBV Panel results			
Patient currently receiving same therapy at	☐ If applicable, when was the patient's last Covid-19 vaccine or booster?			
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.				
1) 3) 2) 4)  MEDICATION ORDERS  Initial Dosing				
MEDICATION ORDERS  Initial Dosing				
MEDICATION ORDERS  Initial Dosing				
Initial Dosing	-1 1			
Ocrevus 600mg infuse IV over 3.5 hours every 6 months  Maintenance Dosing	MEDICATION ORDERS			
Ocrevus 600mg infuse IV over 3.5 hours every 6 months  Maintenance Dosing				
Maintenance Dosing				
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.				
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.				
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.	Duration: ☐ x 6 months ☐ x 1 year ☐ doses			
☐ 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.				
□ 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.	REQUIRED PREMEDICATIONS and OPTIONAL ADDITIONAL PREMEDS and LAB ORDERS			
□ 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.	☐ OPTIONAL: Acetaminophen 650mg PO 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.				
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	In the event of an infusion reaction or adverse event, our covering physicia	n will be notified ar	nd appropriate medical care will be administered.	
PRESCRIBER INFORMATION				
	PRESCRIBER INFORMATION			
Prescriber Name: NPI: Contact:			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.