

Ocrelizumab (Ocrevus)

Provider Order Form rev. 9/18/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name:	DOB:	Patient Phone:
Patient Address:	Patient Email:	
Allergies:	<input type="checkbox"/> NKDA	Weight (lbs/kg): Height (in/cm):
Sex: <input type="checkbox"/> M / <input type="checkbox"/> F	Date of Last Infusion:	Next Due Date: Preferred Location:

DIAGNOSIS (Please provide ICD-10 code in space provided)

<input type="checkbox"/> G35.A Relapsing-Remitting MS	<input type="checkbox"/> G35.B0 Primary Progressive MS, Unspecified	<input type="checkbox"/> G35.B1 Active Primary Progressive MS
<input type="checkbox"/> G35.B2 Non-Active Primary Progressive MS	<input type="checkbox"/> G35.C0 Secondary Progressive MS, Unspecified	<input type="checkbox"/> G35.D MS, Unspecified
<input type="checkbox"/> G35.C1 Active Secondary Progressive MS	<input type="checkbox"/> G35.C2 Non-Active Secondary Progressive MS	<input type="checkbox"/> Other:

THERAPY ADMINISTRATION & DOSING

- ☐ Induction: Administer Ocrevus 300 mg IV in 250 ml 0.9% normal saline on Week 0 and Week 2 followed by 600mg IV in 500 ml 0.9% normal saline 6 months after initial dose
- ☐ Maintenance: Administer Ocrevus 600 mg IV in 500 ml 0.9% normal saline every 6 months
- ☒ Observe patient for hypersensitivity reaction for a period of 60 minutes following each infusion.

ADDITIONAL ORDERS

LABORATORY ORDERS

- ☐ CBC w/ diff ☐ at each dose ☐ every: _____
- ☐ Quantitative Serum Immune Globulin every 3 months
- ☐ Other: _____

PRE-MEDICATION ORDERS

- ☒ Tylenol 500mg
- ☐ Loratadine 10mg PO
- ☐ Pepcid 20mg ☐ PO / ☐ IVP
- ☒ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
- ☒ Solumedrol 125mg IVP
- ☐ Other: _____

NURSING

- ☒ Must have negative hepatitis B and obtain a quantitative immunoglobulin screening prior to start of therapy
- ☒ Hold infusion and notify provider for:
- Signs/symptoms of infection or planned/recent surgery.
 - recent live vaccines
 - pregnancy or neurological symptoms.
- ☒ Monitor vital signs with every rate change, then every 30 minutes and prior to discharge.
- ☒ Patients on maintenance dosing who have not experienced a serious infusion reaction with any previous Ocrevus infusion may be eligible for an increased infusion rate. Reference quick notes for specifics on eligibility and dosing rate table.
- ☒ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name:	Preferred Contact Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI results, Lesion number

Required Labs: Negative Hepatitis B and quantitative immunoglobulin screen.

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.