

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: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

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

G35.A Relapsing-Remitting MS G35.B0 Primary Progressive MS, Unspecified G35.B1 Active Primary Progressive MS
G35.B2 Non-Active Primary Progressive MS G35.C0 Secondary Progressive MS, Unspecified G35.D MS, Unspecified
 G35.C1 Active Secondary Progressive MS G35.C2 Non-Active Secondary Progressive MS 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.