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Ocrevus® (Ocrelizumab) Order Form
Epic Referral: REF115229

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** G35 – Multiple Sclerosis

Rx:

Induction (only check if patient is a new start):

- Ocrevus 300 mg IV infusion every 2 weeks for 2 total doses, then maintenance dosing 6 months later
- Start infusion at 30 mL/hr; increase by 30 mL/hr every 30 minutes to max rate of 180 mL/hr

Maintenance:

- Ocrevus 600 mg IV infusion every 6 months
- Start infusion at 40 mL/hr; increase by 40 mL/hr every 30 minutes to max rate of 200 mL/hr

Order good for: 6 months 1-year Other duration: _____

Pre-meds: (given at each Ocrevus infusion)

- Solumedrol 100 mg IV or Solumedrol _____ mg IV
- Tylenol 1000 mg po or Tylenol 650 mg po
- Benadryl _____ mg po or Benadryl _____ mg IV
- Famotidine 20mg po
- Other: _____

*Solumedrol and benadryl
required per package insert.*

****Please send Hep B Panel results with order, we cannot infuse without Hep B Panel documentation. ***

Other comments: _____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name: _____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____