Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Ocrevus IV Infusion ORDER

(ocrelizumab)

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications, Letter of Medical Necessity and BIF

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis:_____

DX CODES: ***ICD-10*** : _____, _____, _____

Genentech Access to Care Foundation (GATCF) paperwork completed? YES NO

Hepatitis B Virus Screening is required before first dose: ☐ **COPY ATTACHED**
Result Date: _____/_____/_____ Result ***(circle one):*** **Positive Negative**

LABS to be drawn: ☐ CBC Lab Frequency**:** _____
☐ CMP
☐ _____

Pre- Medications:			
Diphenhydramine PO/IV	25mg or 50 mg	☐Yes	☐ No
Acetaminophen PO	650mg	☐Yes	☐ No
Methylprednisolone IV	125 mg	☐Yes	☐ No

Ocrevus (Ocrelizumab) IV

☐ **Initial Dose: Day 1: 300mg**
Day 15: 300mg

☐ **Subsequent Dose 6 months from initial doses: 600mg**

☐ **Maintenance Dosing every 6 months (2 doses/year): 600mg**

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

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