



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*

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: \_\_\_\_\_