



# MEDICATION ORDERS

## OCREVUS (OCRELIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: <input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis     ICD 10 Code: G35 <input type="checkbox"/> Secondary Progressive Multiple Sclerosis     ICD 10 Code: G35 <input type="checkbox"/> Primary Progressive Multiple Sclerosis     ICD 10 Code: G35

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
Previous MS treatments and end of therapy date: 1) 2)	

MEDICATION ORDERS**	
Initial Dosing	<input type="checkbox"/> Ocrevus 300mg IV given at week 0 and 2
Maintenance Dosing	<input type="checkbox"/> Ocrevus 600mg IV given every 6 months
Refills: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses	
<ul style="list-style-type: none"> <li>• New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.</li> <li>• Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.</li> <li>• Please note: Montgomery Cancer Center will follow prescribing information recommendations for initial infusion rate and rate escalation and will observe patient post infusion according to manufacturer recommendations.</li> </ul>	

PREMEDICATIONS
<input checked="" type="checkbox"/> Acetaminophen 1000mg PO, 30 minutes prior to Ocrevus infusion <input checked="" type="checkbox"/> Diphenhydramine 25mg IVP, 30 minutes prior to Ocrevus infusion <input checked="" type="checkbox"/> Methylprednisolone 125mg IVPB, 30 minutes prior to Ocrevus infusion <input type="checkbox"/> Other: _____

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

**Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000**

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207