MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

OCREVUS (OCRELIZUMAB)

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

REFERRAL STATUS
❑ New Referral ❑ Dose or Frequency Change ❑ Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: ❑ Montgomery ❑ Prattville

DIAGNOSIS AND ICD 10 CODE	
❑ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
❑ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
❑ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35

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

MEDICATION ORDERS**	
Initial Dosing	❑ Ocrevus 300mg IV given at week 0 and 2
Maintenance Dosing	❑ Ocrevus 600mg IV given every 6 months

Refills: ❑ x 6 months ❑ x 1 year ❑ _____ doses

- 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.
- 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.
- 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.

PREMEDICATIONS
✓ Acetaminophen 1000mg PO, 30 minutes prior to Ocrevus infusion
✓ Diphenhydramine 25mg IVP, 30 minutes prior to Ocrevus infusion
✓ Methylprednisolone 125mg IVPB, 30 minutes prior to Ocrevus infusion
❑ 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