Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(ocrelizumab)

INFUSE ONE

OCREVUS infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ _____

☐ _____ *(other)*

OCREVUS ORDERS

DOSAGE/FREQUENCY

☐ 300mg IV initial dose, followed by 2 weeks later by a second 300mg IV dose subsequent to first 2 doses, 600mg IV does every 6 months

PATIENT WEIGHT

_____ lbs.

_____ kg

PREMEDICATION PER PRESCRIBING INFORMATION

☑ Solu-medrol 100mg IV 30 minutes prior to each treatment

☐ Diphenhydramine 25mg PO 3-60 minutes prior to each treatment

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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