



1935 W. State Street STE 103
 Garland, TX 75042
 Ph: 972-372-9787
 Fx: 972-787-1492

OCREVUS INFUSION ORDER FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Weight: _____ kg ; Height: _____ in

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> MS Relapsing - Remitting ICD 10 Code: _____	<input type="checkbox"/> Clinically Isolated ICD 10 Code: _____
<input type="checkbox"/> Primary Progressive ICD 10 Code: _____	<input type="checkbox"/> Other: _____ ICD 10 Code: _____
<input type="checkbox"/> Secondary Progressive ICD 10 Code: _____	

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics and Insurance Card <input type="checkbox"/> Hepatitis B: HBsAg & HBcAb antibody results	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and MRI to supporting primary diagnosis <input type="checkbox"/> First Dose -or- <input type="checkbox"/> Last given dose: _____
List Tried & Failed Therapies, including duration of treatment: 1) _____ 2) _____ 3) _____	
<i>PA Guidance:</i> Patient is not receiving Ocrevus in combination interferon beta preparations, dimethyl fumarate, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, teriflunomide, rituximab, belimumab, ofatumumab, alemtuzumab, or mitoxantrone	

ORDERS	
Dosing	<input type="checkbox"/> Ocrevus 300mg in 250ml 0.9% Normal Saline IV at 0 and 2 weeks <input type="checkbox"/> Ocrevus 600mg in 500ml 0.9% Normal Saline IV every 6 months for 1 year <input type="checkbox"/> Solumedrol IV 125mg mg via slow IVP as premed <input type="checkbox"/> Benadryl IV 25-50mg via slow IVP as premed
Nursing Order	1. Nurse to start, pause, or discontinue peripheral or central venous access device as needed 2. Flush IV line with 10-20ml saline before and after each medication dose or as needed 3. Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed 4. Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)	
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:	NPI #:	
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023