OCREVUS (OCRELIZUMAB)
INFUSION ORDERS

REQUIRED INFORMATION

- O This signed order form from the provider
- O Patient demographics & insurance information
- O **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis (ICD-10 below)
- O Hepatitis B antigen and Hepatitis B Core total antibody required

Patient Name: _____ DOB: _____

Allergies: _____ Patient Phone: _____

Diagnosis: ⊙ Multiple Sclerosis (ICD-10: G35)

Labs: Required labs to be drawn by: O Infusion Clinic O Referring Physician

OCREVUS ORDERS

Preferred date of 1st infusion: _____

- O **Loading Dose**: 300mg IV at 0 and 2 weeks, then 600 mg IV every 6 months
- O **Subsequent Dose**: 600 mg IV every 6 months

Protocol Pre-Medication Orders: Solu-Medrol 250mg IV and Benadryl 25mg PO to be given 30 minutes before infusion

**Date of last	O Gilenya	O Tecfidera	O Aubagio
	___/___/_____	___/___/_____	___/___/_____

ADDITIONAL INSTRUCTIONS:

_____

_____

Physician Name: _____ Phone: _____ Fax: _____

**Physician Signature: _____ Date: _____

Please fax the required information to (214) 279-0400 or email to infusionclinic@texasneurology.com

For any questions, please email infusionclinic@texasneurology.com or call (214) 279-0329

Please provide an office email for status updates: _____

INFUSION CLINIC
AT TEXAS NEUROLOGY

Phone: (214) 279-0329
Fax: (214) 279-0400

6301 Gaston Avenue
Suite 100, West Tower
Dallas, TX 75214

texasneurology.com/infusion