

Ocrevus® (Ocrelizumab) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Quantitative Serum IG Levels: _____ Hepatitis B Status: Titer Date: _____ Positive Negative

Ocrevus® (Ocrelizumab) Prescription

Initial Dose: Infuse 300 mg IV over at least 2.5 hours on Week 0 and 2.
 Other: _____

Maintenance Dose: Infuse 600 mg IV over at least 2 hours every 6 months. Refill as directed x 1 year.
 Infuse 600 mg IV over at least 3.5 hours every 6 months. Refill as directed x 1 year.
 Other: _____

If planned maintenance dose is missed, administer dose ASAP and reset dosing schedule to six months after the missed dose was administered. Maintenance doses must be separated by at least 5 months.

Ancillary Orders

Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

- Methylprednisolone sodium succinate _____ mg IV 30 min prior to infusion.
- Diphenhydramine _____ mg PO 30 min before infusion.
- Acetaminophen _____ mg PO 30 min before infusion. Patient may decline.
- Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

- Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
- Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

Lab Orders

- No lab orders
- Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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