Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

Ocrevus IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

Genentech Access to Care Foundation (GATCF) paperwork completed? YES NO

Hepatitis B Virus Screening is required before first dose: ☐ **COPY ATTACHED**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive Negative**

In the past year, what medications for the above diagnosis has the patient tried and failed?

☐ N/A continuation of treatment

Drug	Dose	Dates of use

Labs to be collected: ☐BMP ☐CBC w/o diff ☐CBC w/diff ☐ CMP ☐ ☐ Other:_____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Pre-Medications:			
	Diphenhydramine PO or IV	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No
	Methylprednisolone IV	_____mg	☐Yes ☐ No

Eligible patients will infuse over a shorter time period per PI and Infusion Associates protocol.
Pre-medications will automatically be given for short infusions.

Ocrevus (ocrelizumab) IV:

☐ **Initial** *(3 doses/year)*: **Day 1: 300mg**
Day 15: 300mg
6 months from initial dose: 600mg

☐ **Maintenance Dosing every 6 months** *(2 doses/year)*: **600mg**

Rx Expiration Date: _____/_____/_____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____