O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Ocrevus (Ocrelizumab)

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:			Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:		Office Email:	
Prescribing Providers Name:		Provider NPI:	
Office Address:		City: State:	Zip:
Office Phone Number:		Office Fax Number:	

DIAGNOSIS AND ICD 10 CODE		REQUIRED DOCUMENTATION
☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35	☐ This signed order form by the provider
☐ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35	☐ Patient demographics AND insurance information (copy of cards)
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35	☐ Clinical/Progress notes
☐ Other: _____	ICD 10 Code: _____	☐ Lab and Tests supporting primary diagnosis
		☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
		☐ Hepatitis C Test Results
		☐ TB Test Results
		☐ Immunoglobulin Lab Results

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

PREMEDICATION ORDERS

☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg
☐ Diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)
☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg
☐ Fexofenadine (Allegra) PO ☐ 180mg

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)

Initial Dosing	☐ Ocrevus 300mg IV given at week 0 and 2
Maintenance Dosing	☐ Ocrevus 600 mg IV every 6 months

**Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.*
***Infusions will be titrated to maximum recommended rate as suggested in prescribing information.*

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.