OCREVUS
(ocrelizumab)

FLOURISH™
HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- MRI Results
- Neg. Hep. B Serology
- Immunoglobulins Panel

PRIMARY DIAGNOSIS

☐ G35 Multiple sclerosis
☐ Other:____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, and Methylprednisolone 100mg IV (to begin 30 minutes prior to start of infusion).
☐ Provider Prescribed: ____

PRIMARY MEDICATION ORDER

☐ Ocrevus 300mg IV on Day 1 & Day 15, then 600mg IV every 6 months after initial dose
☐ Ocrevus 600mg IV every 6 months
☐ Other:____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:____________________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

____ ____________________
Provider Signature Date