PURE INFUSION SUITES

INFUSION ORDERS OCREVUS (Ocrelizumab)

UTAH PROVIDERS Fax form to:
1-801-991-6924

ALL OTHER PROVIDERS Fax form to:
1-801-931-2631

you must enter a 1 before the fax number

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

***Please fax all recent labs including TB date/results, Hepatitis B date/results and JCV.**

*ICD 10 CODE

***Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

OCREVUS DOSING

Initial Dose

☐ Infusion One: 300mg IV in 250 ml 0.9% Sodium Chloride Infusion Two (two weeks later): 300mg IV in 250 ml 0.9% Sodium Chloride

Subsequent Doses

☐ 600mg IV in 500ml 0.9% Sodium Chloride - every 6 months

End Date:

OCREVUS PREMEDICATION

☐ Vitals before infusion including temp and every 30 minutes during and for one hour after infusion.

☐ IV methylprednisolone 100mg (or equivalent corticosteroid) 30-60 minutes prior to each Ocrelizumab infusion

☐ Antihistamine 30-60 minutes prior to initiation of therapy

Pepcid:

Zyrtec:

Benadryl:

☐ Dosage _____ Route – IV or P

☐ Other:

OPTIONAL

☐ Tylenol 650mg as needed Route ☐ PO or ☐ IV

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date/Time

Provider Phone | Provider Fax