



	<b>crelizumab)</b> ∣ 0			Phone:	
Address:				State:	Zip:
	ts, please submit with form:				
⊠ Copy of insurance	ce card 🛛 Patient demographic	cs 🛮 History & phys	sical		
□ Labs; including of the label inclu	quantitative serum immunoglobu	lins and HBV (may incl	ude HCV, HIV, TB if indi	icated based on patient r	risk factors)
2. Patient Informa	ition				
	Height: in/cm Weigh				
Is this the first dose?	$?$ $\square$ Yes $\square$ No, date of last infusion	n:f	Next due:	Line type: □PIV	□PICC □Port □Other
3. Diagnosis and C	linical Information				
ICD-10 (required): _	Primary diagn	osis: 🗆 Multiple scler	osis	Other	r:
1. Prescription Inf	ormation				
Medication	Ocrevus 300 mg (30 mg/mL) s	ingle-dose vial(s)			
	☐ Initial and maintenance dos		V on days 1 and 15, the	en 600 mg every 6 month	ns
Dose / Frequency	☐ Maintenance dosing only (initial dosing already complete): Ocrevus 600 mg IV every 6 months				
	☐ Other:				
	☑ Dilute per manufacturer gui	·		diluted solution using a	0.2 or 0.22 micron in-line
Directions	filter, infused per protocol bas  ☐ Other:	ed on dose and tolerat	oility.		
/	☐ Other. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	medications / Refill x 1	12 months		
Quantity / Refills  Dispense all medical supplies necessary for infusion					
5. Additional Orde	ers				
☑ RN to start per	eripheral IV or use existing CVC. R	RN to administer cathet	er flushing per Prompt	tCare Policy and Procedu	ire
	ve standard premedications 30 m				
	mine 25-50 mg PO, indicate if IV is isolone 100 mg slow IV push (or a	-			
	ien 325-650 mg PO	an equivalent conticost	eroia, substitution ii iii	eeded by pharmacy)	
✓ PN to instruct natio	ent to hydrate pre/post infusion a	and adjusts on taking (	OTC dinhanhydramina	and/or acotaminonhon r	oor manufacturor dosing
	needed to prevent/treat post-infu		ore dipriently dramine	and/or acetammophen p	Del manufacturer dosing
	ient for at least 1 hour post infusi		ssible side effects, aller	gic reactions, and when	to contact physician
. Adverse Reaction	n Orders				
Standard anaphy	ylaxis kit to be dispensed and dos	sed per protocol: Epine	phrine IM/SQ (1 mg/m	L vial), diphenhydramine	e IV/IM (50 mg/mL vial),
	ional orders:				, , ,
. Prescriber Inforn	nation				
			Office Contact		
	Fax:			State	<b></b> .p
				NPI:	
Physician Signature	(Substitution Permitted)	Date P	hysician Signature (Di	spense as Written)	Date

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