Ocrevus Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ G35 Multiple Sclerosis

- ☐ Relapsing Form MS
- ☐ Primary Progressive MS

◯ Other: _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD 10 : _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

OCREVUS ORDER

Ocrevus Dose: ◯ Initial Dosing: 300mg Day 0, 300mg Day 15

◯ Maintenance: 600mg every 6 months

Patients Weight: _____

PreMeds: ☐ Benadryl 50mg IV ☐ APAP 500 mg PO ☐ IV methylprednisolone 100mg

Date of last Ocrevus Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____