

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F

Ht: _____ WT: _____ lbs / kg Primary Language: _____ Allergies: _____

Patient Preferred Location: Staten Island West Harrison Manhattan New Paltz Bronx Syosset
 Port Jefferson Millburn Brooklyn Heights Paramus

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

G35 Multiple Sclerosis
 Other: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
NOTE: Include Negative Hepatitis B within 3 years to initiate therapy and Ig Assay (SIC will draw Ig Assay at first infusion if not included in referral)

PRESCRIPTION

Pre-Medications

Tylenol 650mg PO Benadryl 25mg IVP Pepcid 20mg IVP
 Zyrtec 10mg PO Benadryl 50mg PO Solu-medrol 125mg IVP
 Claritin 10mg PO Benadryl 50mg IVP Solu-medrol 250mg IVP
 Benadryl 25mg PO Pepcid 20mg PO Solu-medrol 500mg IVP

Other: _____

Pre Labs:

CBC Iron Panel
 CMP Vitamin D
 CRP Other _____
 ESR

Ocrevus (ocrelizumab)

Loading Dose:

IV: Infuse 300 mg at weeks 0 and 2

Maintenance Dose:

IV: Infuse 600 mg every 6 months for 1 year

Rate: Choose one:

Infuse over 3.5 hours
 Infuse over 2 hours

In the event of an adverse reaction occurring at a Specialty Infusion suite, utilize the Specialty Infusion adverse reaction protocol.

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Supervising Provider (if applicable) _____

Date: _____ NPI#: _____ Specialty: _____

Practice Name: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____