FUSE INFUSION
175 Memorial Highway. Suite 1-1
New Rochelle, NY
10801
914-460-4891
fuse@fuseinfusion.com
914-460-4571

(ocrelizumab)

OCREVUS infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg IV

☐ Cetirizine 10mg IV

☐ _____

☐ _____
(other)

OCREVUS ORDERS

DOSAGE/FREQUENCY

○ 300mg IV initial dose, followed by 2 weeks later by a second 300mg IV dose

subsequent to first 2 doses, 600mg IV does every 6 months

PATIENT WEIGHT

_____ lbs.

_____ kg

PREMEDICATION PER PRESCRIBING INFORMATION

◉ Solu-medrol 100mg IV 30 minutes prior to each treatment

○ Diphenhydramine 25mg IV 3-60 minutes prior to each treatment

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____