

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

Multiple Sclerosis

ICD-10 Code: G35

Other _____

ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
- Required Information:
 - Hepatitis B virus screening
 - Quantitative serum immunoglobulin screening (including IgM, IgA, IgG)

Height: _____
Weight: _____

Ocrevus (ocrelizumab) Orders:

- Loading Dose:** Administer 300 mg IV on week 0 and week 2 to provide 2 total doses
- Maintenance Dose:** Administer 600 mg IV once every 6 months for 12 months

Pre-Medication Orders: 30 minutes prior to infusion

- Acetaminophen 650 mg PO
- Diphenhydramine 50 mg PO
- Methylprednisolone 125 mg IV
- Other: _____

Lab Orders:

- CBC with Diff, CMP every 6 months
- IgG and Vitamin D every 12 months
- Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

Prescriber's Signature

Date

Prescriber's Printed Name

Contact Phone #:

Please fax the completed order form and all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus