P R O V I S

Provis Patient No.

MEDICATION ORDER FORM

Ocrelizumab (Ocrevus®)

Patient's Surname	Given Name & Initials	Date of Birth ______ / ______ / __________ dd mm yyyy
Referring Physician		

Patient's Height: __________ cm Weight: __________ kg BSA: ___________ m^2	Cycle 1: (at 0, 2, and 6 months) …………………………….. Maintenance Cycles: …………………………………………

Pre-Medication

- ☐ Methylprednisolone 100 mg IV 30 minutes prior to treatment
- ☐ Acetaminophen 650mg PO 30 minutes prior to treatment and q4h for aches or temp change greater than 1 degrees C.
- ☐ Diphenhydramine 25 – 50 mg IV 30 – 60 minutes prior to treatment
- ☐ Epinephrine 0.2 – 0.5 mg IV as needed for anaphylaxis
- ☐ O_2 nasal cannula at 2-5 liters / hr, if needed for chest pain or dyspnea
- ☐ Other ……………………………

Medication prescribed:

Ocrelizumab 300 mg or __________ IV in 250ml NS over 2.5 hours

☐ Induction : Weeks 0, 2

And

Ocrelizumab 600 mg or __________ IV in 500ml NS over 3.5 hours

☐ q 6months or …………(**please specify)**

(For Provis Use Only) Tx 1: ________________________ Tx 2: ________________________ Tx 3: ________________________ Tx 4: ________________________	

Referring Physician's Signature	______ / ______ / __________ dd mm yyyy
Signature of Provis Physician	______ / ______ / __________ dd mm yyyy

Fax completed form to: 416-532-3635

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